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Exploring Women's Lived Experiences and Expectations with In-Patient Maternity Care within the U.S. Military Healthcare System

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Abstract

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Michelle A. Recame-Osborne

M.S., Walden University, 2013

B.S., Boise State University, 2009

Dissertation Submitted in Partial Fulfillment

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Abstract

Satisfaction with in-patient maternity care within the Military Healthcare System (MHS) continues to score significantly below national benchmarks when compared to civilian hospitals and doctors. Lack of independent, qualitative research in this area has left the MHS with few answers as to why patients are satisfied, but still unhappy, with specific aspects of care. Discrepancy theory was used in conjunction with grounded theory as the foundation and framework for understanding the expectations and experiences of women who have given birth in the MHS within the past year. Using grounded theory and a hermeneutical approach to interview participants, qualitative data were collected to understand these women's expectations, experiences, and satisfaction. Participants were active duty dependents who had given birth within the last year at a local hospital and used TRICARE as their only insurance. They were recruited through the base's local community online network and 12 women total participated. Data were carefully analyzed using transcriptions and were subsequently grouped into common patterns, and then into themes. Findings revealed 3 key themes: (a) participants had one or more complaints or complications with their maternity care; (b) previous experiences on standard care were mostly negative, and (c) differences in satisfaction may be seen when a patient's personal experiences and beliefs about an occurrence are met or excused. This study contributes to social change by adding previously unexplored qualitative data to the military healthcare community in a population that had not been investigated in this manner and has the potential to increase understanding about the population, as well as how experiences, expectations, and satisfaction coexist.

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Chapter 1: Introduction to the Study

Background of the Study

Within the Military Healthcare System (MHS) the delivery of care has seen various changes over the past 50 years, from the creation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1967, to the formation of TRICARE in 1996, and the enhancement of medical programs through the Defense Authorization Act of 2002 (Granger et al., 2010). The MHS was created to establish a medical network of civilian and active duty personnel charged with providing a range of services for U.S. military members and their families; this included the adoption of the patient-centered medical home (PCMH) initiative, which sought to provide accessible, affordable, and high-quality care for all MHS beneficiaries (Hudak et al., 2013). The Department of Defense's (DoD) most recent release of data indicated that this network included 59 civilian hospitals and 364 health clinics, with a budget of $50 million dollars (Jacobson & Jensen, 2011). For the last 12 years, the DoD has provided these services through TRICARE, which is responsible for all active duty, retired service members, and their families worldwide (Health.mil, n.d.; Kugler, 2011). While the goals of the DoD are to "ensure the highest standard[s] of care" (as cited by Jacobson & Jensen, 2011, p. 255), the 2012 TRICARE Inpatient Satisfaction Survey (TRISS) reported an overall below average hospital rating when compared to national norms, with the lowest scores coming from OB-GYN care received during labor and deliver (LD) hospital stays (TRICARE, 2012). A review of the TRISS data on in-patient OB-GYN services and LD care revealed relatively high rankings for all survey components (Appendix A), but fell significantly below national benchmarks on *Overall Hospital Rating* and patients' likelihood to

Recommend the Hospital to family and friends (TRICARE, 2012). This suggests there are areas of care that are being overlooked. TRICARE's survey is the only evaluation used to assess women's care received during LD, therefore this study proposed to conduct a qualitative investigation to understand women's experiences and expectations with LD in the MHS, and to further analyze any recurring patterns for the creation of a new theory on the most prevalent phenomena within the data.

Despite extensive efforts by the DoD to ensure quality care across the board, varying practices worldwide may account for certain discrepancies. Since the MHS is composed of a combination of civilian networks/purchased care (PC) and direct care (DC) through Military Treatment Facilities (MTF), establishing a single set of rules and regulations can be challenging (Hudak et al., 2013). In addition to these obstacles, each branch of the military is responsible for their own implementation of the PCMH, as well as determining which services can be supported at each base location (Hudak et al., 2013; Kugler, 2011). Furthermore, TRICARE is subdivided into two divisions of services for stateside active duty members and their families. These include different coverage options and are referred to as TRICARE Prime and TRICARE Standard and Extra (TRICARE, 2013b). An analysis of the 2012 TRISS survey showed that PC for in-patient LD OB-GYN services and care scored slightly higher than DC in overall satisfaction, but again, fell significantly short of national benchmarks for *Overall Hospital Rating* (Appendix B & C) (TRICARE, 2012).

According to TRICARE (2012), the results of these surveys not only measure healthcare performance, but may also directly improve the overall quality of care received by beneficiaries during their LD hospital stay. This can be especially important

in the long-term and short-term health of mother and baby (Grummer-Strawn et al., 2013). Routine care practices within the hospital setting can pose significant barriers to breastfeeding (Grummer-Strawn et al., 2013) and unwelcoming environments can prolong the recovery period (TRICARE, 2012). For these reasons, it is imperative to discover the aspects of LD hospital services and care that patients feel may lead to a more satisfactory experience, as well as how they may be able to be improved upon, so that the MHS can provide upstanding quality care.

Problem Statement

Several studies have examined a variety of issues concerning maternity care within the MHS (Christ et al., 2007, Kennedy et al., 2011; Sylvia et al., 2001), but few evaluations have qualitatively focused on understanding a woman's experiences and overall expectations of treatment during LD stays (Harriott et al., 2005). Harriott et al. (2005) were the last researchers to investigate the potential factors that affected care by looking at the satisfaction levels of women within the MHS and which phenomena were associated with a woman's likelihood of recommending the medical treatment facility for LD. They found that most of the factors assessed were important in determining if women would recommend the hospital in which they delivered, but that over half of the patients were not satisfied with the care they received. Their findings were the first of their kind, but no further research has explored these concepts since then. A continuation of significantly below average ratings (TRICARE, 2012) indicates that some areas are being unexplored. Changes in this area could also lead to higher breastfeeding rates and faster recovery times (Bick et al., 2012; TRICARE, 2012).

Policy makers and hospital administrators cannot properly address the issues or adequately repair the system without further qualitative investigation into *why* women are unhappy with their care received during LD stays. A more in-depth examination has the potential to uncover what previous research has not been able to. Understanding the birthing process through expectations and experiences may uncover hidden factors that lead women to rate their hospital stays as unsatisfactory, which can help improve the labor and delivery process, as well as assist in changing how care is provided.

While this study is not specifically looking at satisfaction, rather the labor and delivery process as a whole, it must be stated and understood that the phenomenon of satisfaction is an underlying component and *product* of experiences and expectations. In order to understand how to improve the system, it must be investigated as to why patients are not satisfied and then try to create a theory that explains the process, which comes from experiences and expectations that may play a role in overall satisfaction. Discrepancy theory (DT), which states that a patient's satisfaction can be "determined by the differences between what is expected and what actually happens" (Sawyer et al., 2013, p. 2), is a proper fit for this investigation

Purpose of the Study

The purpose of this ground theory study was to understand the relationship among expectations, experiences, and satisfaction with labor and delivery hospital stays in the MHS.

Nature of the Study

This study used a grounded theory and hermeneutical approach to interview participants and obtain data to understand women's lived experiences and expectations

with labor and deliver hospital stays in the MHS. Through thorough analysis, patterns among phenomena were used in an attempt to establish a new theoretical relationship among expectations, experiences, and satisfaction with maternity care within the MHS.

Research Question

The purpose of this qualitative study was to investigate women's experiences and expectations with labor and deliver care within the MHS, with the hopes of discovering any hidden factors of care that were associated with positive and negative feelings towards OB-GYN services and overall care received during LB stays, which could lead to the development of a new theory. By accessing mothers who had recently given birth as a dependent, or active duty member, this investigation aimed to answer the following questions:

RQ1: What are women's lived experiences with labor and deliver hospital stays in the Military Healthcare System?

RQ2: Prior to delivery, what were women's expectations with labor and deliver hospital stays in the Military Healthcare System?

RQ3: What are some of the inconsistencies seen between experiences and expectations?

As a subquestion, this investigation hoped to determine if any common themes would arise between satisfaction, expectations, and experiences. The subquestion was: Had experiences or expectations before being admitted for labor and delivery altered an individual's outlook as described by the Discrepancy theory (Sawyer et al., 2013)?

Analysis for the Theoretical Basis of the Study

The research in this area has been limited, and most investigations have relied on quantitative methods (Brady, 1998). The majority of patient satisfaction models were created in the early 1980s, before patient centered care became the focus of hospitals, doctors, and executives; a few principle theories are still used today for quantitative purposes, but do not align well with qualitative methods due to their statistical nature (Department of Health and Aging, 2006). As noted by Brady (1998), very little is known about this phenomenon in general and research has not used qualitative methods to investigate women's perceptions about military maternity care and satisfaction. In general, the medical field has neglected to properly address maternity care, thus leaving gaps in the literature with regard to LD patient satisfaction theories. At best, the healthcare community has been able to develop some beliefs regarding patient satisfaction with emergency room care (Aragon & Gesell, 2003), general practice (Baker, 1997), and elderly services (Raftopoulos, 2005). At the center of these theories lies the idea that an individual's perception of the quality of care received is based upon the patient's expectations and interactions with their primary care manager (PCM) and other hospital staff (Aragon & Gesell, 2003; Baker, 1997; Raftopoulos, 2005). These models are idealist for those whose visits are brief, but maternity care is a lengthy process, in which many components can lead to a negative or positive experience (Janssen, Dennis, & Reime, 2006).

Typically, investigations focus on theories that have been previously established by other professionals within the field. These studies help the examiner to confirm their own data based on existing knowledge and are often referred to as the *top-down*

approach (Burney, 2008), or deductive theory. Conversely, inductive theory, or the *bottom up* approach, focuses on specific observations to make broader generalizations about a particular population and is more closely associated with qualitative research (Burney, 2008). The use of qualitative measures work best when there are a lack of adequate theories to explain particular populations, or when existing models do not effectively reflect the complexity of the issues being examined (Creswell, 2013). According to Creswell (2013), when the current theories available do not fit the problem, qualitative research becomes an important tool to explore the uniqueness of the issue. Since this particular area of research has been relatively unexplored, the use of inductive theory was more advantageous for this study. This approach allowed for an adequate, qualitative, investigation to search for particular patterns between participants, the analysis of rich and meaningful data, and the attempt of creating a new theory (Burney, 2008). The selected approach for this dissertation was grounded theory (GT). GT is most appropriate, as its primary focus is to develop new theories grounded on data drawn from participants' own viewpoints (Charmaz, 2006; Creswell, 2013).

Definition of Terms

In-patient care: Any services, including care, received by a woman from the time she arrived at the hospital for check in, until the time that she was discharged and left the facilities (TRICARE, 2012).

OB-GYN care: This term is more often used by TRICARE to describe a woman's stay for labor and delivery. This time period is from check-in to discharge and sometimes includes follow up services received within the next few days (TRICARE, 2012).

Tricare prime: Prime insurance is the health care option that allows beneficiaries to

receive most of their routine care through their primary care manager (PCM) who is selected, or assigned, at a military hospital or clinic, a civilian network provider, or a primary care physician in the US Family Health Plan, depending on the location of the patient and the service (TRICARE, 2012).

TRICARE standard: This is an option for beneficiaries that allows the patient to manage their own health care, as well as gives an individual the ability and freedom to seek care from any TRICARE-authorized (TRICARE, 2012).

Significance of the Study

The birthing process can be an exciting, frightening, and memorable experience for an expecting mother. During this time, it is important that a woman is cared for, educated, and informed, to ensure that her infant has the best start. Although brief, a mother's stay in the hospital or childbirth center can have a lasting impact on her baby's health (Center for Disease Control [CDC], 2009). For example, the likelihood of an infant being breastfed is influenced by a mother's experiences during her time at the medical facility (CDC, 2009). Thus it is imperative that the events during this short stay are positive and nurturing (CDC, 2009; Maternity Care Coalition [MCC], 2012). Researchers also note that satisfaction with the birthing process can pose significant psychological and social effects that can have both immediate and long-term consequences on a mother's health and the relationship she develops with her infant (Jimenez, Klien, Hivon, & Mason, 2010; Wilde-Larsson, Larsson, Kvist, & Sandin-Bojo, 2009).

Aside from yearly evaluation surveys conducted through TRICARE, investigations in this area have been sparse (Christ et al., 2007; Harriott et al., 2005; Kennedy et al., 2011; Sylvia et al., 2001). Furthermore, an overview of TRICARE's

(2008, 2009) last three published reports denotes a continuous finding of below average scores for OB-GYN LD care received during hospital stays (Appendix D & E). By exploring women's experiences and expectations with the LD process, medical facilities within the MHS can begin to understand how to improve the quality of care and overall patient satisfaction.

Creating social change begins with a full understanding of what it is patients need and want from their care. Through thorough, qualitative investigation, this may be possible to achieve. Since the mid-20th century, investigations in this area have slowly become less prevalent in the literature. This may be due to the healthcare community's heavy reliance on what they believe are satisfactory instruments for measuring care, such as the TRISS, the Consumer Assessment of Healthcare Provides and Systems survey sets (CAHPS), and the U.S. Department of Health and Human Services' (2014) Health Center Patient Satisfaction Survey (HCAPSS). In a world that is interested in fast, easy, and cost-effective ways of determining patient satisfaction, these short, standardized, evaluations provide the medical community with what they consider are the most important aspects of care (US. Department of Health and Human Services, 2014). However, current findings still show that patients are receiving less than satisfactory care in some areas, especially in the military healthcare setting (TRICARE, 2012). Surveys like the TRISS are particularly important because they not only tell researchers about the care received within the military community, but in the private sectors as well, since a great deal of services received come from civilian hospitals (TRICARE, 2012). Independent research within this particular area is outdated, but a reevaluation of the current status of the MHS allows policy makers and hospital administrators to address the

needs of women today. Conducting qualitative inquiries, rather than relying on standardized instruments, allows for a deeper understand of patient experiences; social change can then be created by ensuring women are receiving the best possible care based on the understating of the data. Although a total transformation may not occur overnight, presenting more objective information about the needs of women within the MHS has the potential to have a positive influence on future changes in policies and procedures.

Summary and Transition

The MHS continues to score significantly below national benchmarks when compared to their civilian counterparts, with the largest disparities seen in in-patient OB-GYN care for mothers who have recently given birth within the MHS (TRICARE, 2012). Yearly evaluations consistently show that while patients are satisfied with specific factors of care such as communication, friendliness, and hospital conditions, they would still not recommend to family and friends, and their overall satisfaction is significantly low (TRICARE, 2012). This suggests that there may be more to satisfaction of care than what standardized instruments can measure. In addition to the gap in adequate measurements and theories, little research has been conducted specifically in this area. Harriot et al. (2005) were the last to conduct an empirical investigation, but found similar results as TRICARE. Since then, this field has not seen a reevaluation from any other independent researchers. The results of this investigation have the potential to create positive social change by increasing patient satisfaction, quality of care, and to encourage a meaningful reformation of how the medical community approachs patient satisfaction.

This investigation was conducted to understand the lived experiences and expectations of women who have given birth within the MHS and to attempt to develop a

novel theory grounded in the data. The following chapters include an in-depth literature review of maternity and labor and delivery care around the world, within the U.S., and specifically within the MHS of the United States (Chapter 2), as well as an explanation of the research methods (Chapter 3), results (Chapter 4), and conclusions (Chapter 5).

Chapter 2: Literature Review

The idea of better healthcare is not a new concept. From policy makers to hospital administrative staff and researchers, the notion of improved care has been around since the early 1960s (Thiedke, 2007). However, after *community health planning* died out in the late 1980s, research in this area did not have a significant impact on the healthcare community again till the early 2000s (Laruffa, 2006; Sawyer et al., 2013; Sofaer & Firminher, 2005; Wilde-Larsson et al., 2009). This renewed interest began to emerge once more, after the movement towards *patient-centered care* came to the forefront of medical communities and beneficiaries began to demand more transparency and accountability from professionals (Sawyer et al., 2013). Implementing new policies and procedures that benefit both stakeholders and patients is challenging though, because the understanding of quality care, satisfaction, and patient perceptions are still greatly misunderstood as it is still a relatively new area of thought. There is a great deal of research within the medical community about what factors lead individuals to feel satisfied and that they have received quality care, but some argue that patients themselves do not fully understand the scope of what quality means (Sofaer & Firminger, 2005). Understanding why has now become more important. It is not just imperative that researchers know what aspects of care patients feel are still unsatisfactory, but what factors may lead to this impression, including, but not limited to, perceptions, expectations, and their understanding of the care they are receiving (Redshaw, 2008; Sofaer & Firminger, 2005).

Patient satisfaction has been shown to be an acceptable indicator of the quality of care received, thus understanding patients' experiences and perceptions can be helpful in

enhancing overall healthcare services (Handler, Raube, Kelley, & Giachello, 1996; Irish Department of Health and Children [DOHC], 2003; Sawyer et al., 2013). Medical facilities have gone through great lengths to determine their patients' overall treatment satisfaction by implementing several investigative surveys in an effort to provide exceptional quality care (Aragon & Gesell, 2003; Baker, 1997; Raftopoulos, 2005). Since the mid-21st century, there has been a steady decline in the number of independent studies being conducted on patient satisfaction within the U.S (Aragon & Gesell, 2003). This may be due to the implementation of standardized satisfaction surveys that are being used across the healthcare community. These instruments may have been able to effectively gauge how well patients felt about hospital services, doctor visits, and other aspects of care when they were first introduced (Aragon & Gesell, 2003; Baker, 1997; Raftopoulos, 2005), but in a rapidly changing environment, like the healthcare industry, they can quickly become inefficient if they do not adapt to evolving policies, procedures, and improved medical treatments. Sofaer and Firminger (2005) also note that patient satisfaction surveys are prone to *ceiling effects*, in which it becomes undeterminable if physicians are merely providing *acceptable* or outstanding care.

Within the U.S. military population, similar yearly healthcare surveys are distributed to patients in an attempt to identify the factors that significantly affect patient satisfaction level, but little is understood about the specific aspects of care that are associated with satisfactory, or dissatisfactory, experiences within this population (Harriott et al., 2005). Present military medical surveys also lack the same type of detailed epidemiological data that are common within civilian populations (Hourani, 1996). Like their counterpart's standardized instruments, TRICARE's yearly evaluation

have seen little to no change in its approach over the last several years, and have even shortened the length to make surveys less time consuming (Babeu, Bannick, & Marshall, 2011; TRICARE, 2012).

Patient satisfaction is a complex concept that has somewhat eluded professionals since its use in understanding quality care. This may be due to the idea that satisfaction alone does not equal superior service or quality; rather it simply represents the impression that the services received were acceptable or not (Sofaer & Firminger, 2005). It is also a multifaceted idea that can be affected by various intrapersonal beliefs, preconceptions of care, expectations, and experiences after receiving services (Orgen & Bekar, 2010; Redshaw, 2008; Sofaer & Firminger, 2005). Redshaw (2008) noted that the notion of satisfaction could be seen by some as an artificial concept, created solely to objectify and monitor standards of care, but that the research has shown it to be a suitable determinant for evaluating the discrepancies between expectations and actual events. Inconstancies in what patients anticipate from their care and what they actually receive may be the key to understanding how to improve services, but standardized evaluations and surveys lack the in-depth analysis needed to improve face validly (Redshaw, 2008; Sofaer, et al., 2005). The use of qualitative methods, through interviews and focus groups, has the ability to provide meaningful data that would be otherwise missed, particularly in the areas of patient perceptions and expectations (Sofaer et al., 2005). Support for qualitative investigations on the relationship between satisfaction, expectations, and perceptions have been overwhelmingly positive, however it is also important to understand some of its limitations.

It has been noted that patient satisfaction is an adequate measurement of quality

of care (DOHC, 2003; Handler et al., 1996; Sawyer et al., 2013; Sofaer & Firminger, 2005), but if satisfaction is a consequence of expectations, experiences, and perceptions, then researchers can never confirm if the variations seen among patients are the result of discrepancies in their expectations, or their experiences/perceptions. For example, a patient with lower expectations may be more satisfied with an area of care than an individual who had higher expectations for the same service. This obstacle can become problematic when trying to improve healthcare, because professionals can never be sure if there is a need for quality care improvements or their participants had unreasonable standards (Sofaer & Firminger, 2005). To detour this effect, it is suggested that researchers understand the level and reason for dissatisfaction through qualitative investigation (Sofaer & Firminger, 2005).

Across the general healthcare community, several key factors have been shown to affect patient satisfaction in qualitative analysis; these included physical and emotional support, access to staff, communication, efficiency, and effective organization (Sofaer & Firminger, 2005). According to Sofaer et al. (2005), these concepts have helped shape current standardized satisfaction surveys, but they still lack the in-depth examination of the connection between patients' perceptions and expectations with overall satisfaction and quality of care. The type of service being received can also have an effect on varying factors due to the differences in processes and procedures.

The following literature review focuses on the aspects of maternity care that affect overall patient satisfaction for the MHS, the U.S. civilian sector, as well as other global healthcare systems. Research within the military system has been previously conducted (Harriott et al., 2005), but qualitative measures have been relatively neglected, or

marginalized, in these investigations of satisfaction with maternity care (Bassoff et al., 1986; Christ et al., 2007; Harriott et al., 2005; Kennedy et al., 2011; Sylvia et al., 2001); furthermore, recent changes in policy, coverage, and treatment options necessitate a reevaluation of the current data (Bennett, 2011). An in-depth analysis of the current state of the military system as a whole is also provided.

The literature review process was completed over several years during coursework with Walden University, as well as specified searches done while completing dissertation related work. Search engines varied through the Walden University Library, the local base library, and Google Scholar. Databases included, but were not limited to, EBSCO, ProQuest, Google, and National Institute of Health. Specific searches include, but were not limited to, *military healthcare system, maternity care military, OB-GYN "military", satisfaction healthcare, measuring satisfaction, theory in satisfaction/satisfaction theories, satisfaction "maternity care", satisfaction military maternity care, labor and delivery satisfaction, discrepancy theory, psychology "discrepancy theory", healthcare "discrepancy theory", quality "discrepancy theory",* and *quality "discrepancy theory"*. Quotation marks denote some of the delimiters used.

Most Recent Empirical Literature

Within the healthcare community, patient satisfaction has been shown to be an acceptable measure of the quality of care received Handler, Raube, Kelley, & Giachello, 1996; DOHC, 2003; Sawyer et al., 2013; however, quality assurance (QA) may mean different things to patients and providers. According to the National Center for Biotechnology Information (NCIB, n.d), QA includes all activities and programs aimed at improving the quality of care received within the medical setting. This concept includes,

but is not limited to, the assessment of the delivery of care, identifying inadequacies, and developing new ways of increasing satisfaction. The World Health Organization (WHO, 2006) noted that while the improvement of quality care has been a top global priority, it still remains an area that is less than acceptable results. This may be due to a lack of understanding of the factors that predict a patients' likelihood to feel that they received quality care. It has been suggested that a more in-depth analysis be given from the view of the patient, rather than the success of the medical outcome (Perides, 2002). Understanding patients' perceptions, expectations, and experiences has the ability to increase the healthcare community's comprehension of how to develop programs directed at improving quality care from the patient's perspective.

Several studies have examined a variety of issues concerning maternity care within the MHS as a whole (Christ et al., 2007; Kennedy et al., 2011; Sylvia et al., 2001), but few have focused explicitly on the aspects of treatment that affect a woman's overall experience during LD hospital stays and feelings towards OB-GYN care and services (Harriott et al., 2005;). In an earlier attempt to address general important issues concerning maternity care, Sylvia et al. (2001) collected data on the most and least significant needs, as stated by expectant mothers. Analysis of the data showed that participants (N = 328) noted *quality of care* as the most important aspect that influenced their choice of provider; other high ranking factors included the consistency of healthcare, ability to have options, and personalized attention (Sylvia et al., 2001). Although these women rated quality of care fairly high, over half of stateside mothers preferred to see a doctor off base, rather than on base (Sylvia et al., 2001). This choice ultimately results in higher spending for the military, which creates higher premiums for

some military members (Bennett, 2011).

Subsequent evaluations of military maternity care have shown dissimilar results. In an analysis of satisfaction within the MHS, over half of the participants (N = 1,124) stated they would not recommend a medical military facility to their friends or family (Harriott et al., 2005). In comparison, military hospitals performed significantly below the national average. No significant differences were seen in continuity, emotional support, or respect for patient preference, but all other dimensions of care were below national standards. It also included: "courtesy and availability of staff, confidence and trust in provider, treatment with respect and dignity, information and education, physical comfort, involvement of family and friends, involvement in decision making, [and] coordination of care" (Harriott et al., 2005, p. 8). Data from the investigation revealed a strong disconnect between military healthcare providers and maternity patients. Harriott et al. (2005) has suggested that future research address the recent efforts of *patient-centered care* and the 2002 National Defense Authorization Act, which has shifted maternity care to civilian supported facilities.

Alternative methods for providing adequate patient-centered care have been attempted by several researchers (Calhoun, Brandsma, & Vannatta, 2000; Christ et al., 2007), but use of these practices across the military has not been implemented. Rather, each facility has been left to determine best practices based upon location, needs of the community, and availability. In a study conducted by Christ et al. (2007), participants (N = 630) were gathered from Tripler Army Medical Center, in Hawaii, to determine if in-home, well-baby visits had an effect on the satisfaction of care when compared to individuals who only received in-clinic visits for their infants 2-week checkup. Air Force

and Army infants were strictly evaluated at the base clinic, while Navy and Marine Corps mothers were given the option to receive their infant's check up from home; a total of N = 150 choose to have an in-home visit (Christ et al., 2007). These findings show specific aspects of care that may be transferable to LD stays and other factors that can be improved upon.

By using qualitative methods, mothers were asked to answer yes or no with regard to whether they had received specific information, or if they were satisfied with particular aspects of their visit, such as length of time spent on infant care, advice, and overall quality (Christ et al., 2007). An analysis of the data showed that in-home visits were preferred (56.8%) over clinical check ups for both treatment groups. Of the home visit recipients, 91.3% expressed their preference for in-home checkups over visiting the base clinic; the most commonly cited reasons were that: (a) it was more personable (3.6%), (b) more convenient (81.8%), and (c) they did not want to take the baby out of the home (10.9%) (Christ et al., 2007).

Overall, more mothers (56.8%) noted a desire for in-home checkups, but higher satisfaction was not associated with either group; no significant difference was found with the level of overall care (Christ et al., 2007). While this research is important for determining additional aspects of maternal care, if this study were to be replicated several issues would need to be addressed. The first would be the nonrandomization of treatment groups. By specifically dividing participants by branch, the results could have been altered. In addition, the researchers might benefit from a larger sample in a different location.

Global Maternity Care

Quality assurance of intrapartum and postnatal care during a woman's hospital stay are not exclusive to the military community. The interest of proper support, education, and satisfaction extend well into the civilian population in the U.S. and across the globe (Aghlmand et al., 2008; Backstrom, Wahn, & Ekstrom, 2010; Bick et al., 2012; Brown et al., 2007; Kabakian-Khasholian, Campbell, Shediac-Rizallah, & Ghorayeb, 2000; Schmied et al., 2009; Van Tejilingen et al., 2003). According to Bick et al. (2012), the UK has also found in-patient care to be an area that is less than satisfactory. Their investigation revealed that most women were unhappy with the level of support in several areas including breastfeeding. Their research goals were to determine how to make a more seamless transition from birth to discharge by identifying the barriers that contributed to women's unsatisfactory views of their birthing experience. Data revealed that higher support for breastfeeding, longer stays in the delivery suite, and education on infant care lead to significantly higher rates ($p = .016$) of long-term breastfeeding and more satisfaction with the overall process ($p = .019$) (Bick et al. 2012). These small changes were able to improve women's satisfaction within hospital ward and did not exceed current resources available to the staff (Bick et al. 2012), suggesting that other minor factors of care could significantly alter satisfaction levels as well. Other UK studies of in-patient maternity care have found similar results with regards to breastfeeding, but propose that a variety of factors may also contribute to overall lack of satisfaction, including the ward environment, attitude of the staff, infant education, and low expectations of the hospital facility (Beake et al., 2010).

The TRISS survey (TRICARE, 2012) has never addressed breastfeeding as a quality of care factor, but may be an area of interest that needs further evaluation due to its significant benefits (Rishel & Sweeney, 2005). In a study conducted by Backstorm et al. (2010), researchers found that improved support of breastfeeding made new mothers feel more confident and more satisfied overall. Uncertainty and insecurity was found to emerge when women stated that support was lacking, which in turn lead to reports of dissatisfaction (Backstrom et al., 2010). The participants noted a strong desire for confirmation, someone to listen to their needs, more one-on-one time, and follow ups from healthcare professionals (Backstrom et al., 2010). When these factors of care were provided, the women stated that they felt more positive about themselves and were more satisfied overall. Continuous support after discharge was also noted to be a factor of importance, suggesting that postnatal care should not cease after mother and infant are released from the hospital.

Enabling women with information and choice is an effective way for expectant mothers to feel that they have control over their maternity care and birthing process. It is not only important for women to perceive that they have authority over various aspects of their pregnancy, but to be able to exercise those informed choices as well (Baker, Choi, Henshaw, & Tree, 2005; O'Cathain et al., 2001). Research in this area has found that women who chose less conventional methods, such as at home births or declining regular ultrasounds, often feel that they have less opportunity to exercise informed choices (O'Cathain et al, 2001). The extent to which this may affect a woman's perceptions of care are unknown but may be a significant aspect of understanding the complex idea of satisfaction. O'Cathain et al.'s (2001) research found that roughly 46% of participants felt

that they were not able to exercise their informed decisions when it came to antenatal and postnatal care. These findings were highly variable depending on the women's education level, occupation, and number of pregnancies, but were still statistically significant. One specific area of care that women felt the least control over was fetal heart monitoring during labor and delivery. O'Cathain et al. (2001) weakly contributes this to a lack of information and education on the topic. However, this could also be a common procedure, which is not typically regarded as an optional service, as opposed to ultrasounds scans, screening for birth defects, epidurals, and breastfeeding (O'Cathain et al., 2001). Other researchers have also found that some women felt they had little understanding of why physicians chose to perform particular procedures without their consent or against their wishes (Baker et al., 2005). The use of suction was noted as one of the techniques used without informing the patient. One participant even stated that she felt pressured to take an epidural, despite her consistent requests to avoid the anesthesia (Baker et al., 2005). These examples of miscommunication and unfulfilled requests of the patients' informed decisions made the participants feel as though they had less control over the birthing experience, and it affected their perceptions of satisfaction with the delivery process (Baker et al., 2005). The perception of control goes well beyond the basic measurements of communication with doctors/nurses that are often evaluated in standard hospital surveys like the TRISS and Consumer Assessment of Healthcare Providers and Systems (CAHPS). It is a factor that may play a vital role on satisfaction, regardless of how common or uncommon the procedure is.

The relationship and communication styles of doctors and nurses can vary from person to person, but may also be a factor that can affect overall satisfaction with the

birthing experience. In an analysis of midwife-led versus physician-led care, researchers found that midwife driven practices improved overall satisfaction, reduced the number of procedures used during labor, and positively increased physiological outcomes (Sutcliffe et al., 2012). Sutcliffe et al. (2012) contribute this association to the philosophies of midwife care, which strive to provide a more minimalized intervention led childbirth, continual communication, and full patient control over the birthing experience. Participants specifically noted several factors that contributed to higher satisfaction ratings, and included more confidence with midwife-led care, greater experience with getting questions answered, and a higher perception of control during labor. Patients who chose to deliver with a midwife also had lower rates of fetal monitoring, antenatal hospitalization, and higher rates of breastfeeding. However, there was no significant difference in postpartum depression, duration of postnatal stay, or infant outcomes (Sutcliffe et al., 2012). Similar to O'Cathain et al. (2012), patient control appears to be an important factor with the birthing experience. More research is needed in this area to confirm the data, but communication and the perception of patient control may be a contributing factor to satisfaction.

Patient preferences and maternity care issues seem to be consistent globally. Several studies have found many of the same concerns that are important to new and expectant mothers despite the method of delivery, location, or midwife-led versus physician-led. The following items are not all-inclusive, but denote some of the most common themes found throughout the literature: continuity of caregiver, pain relief, fetal monitoring, homely environment, caring staff, educational and breastfeeding support, and more control over the decision making process (Aghlmand et al., 2008; Gibbins &

Thomson, 2001; Hundley, Ryan, & Graham, 2001; Jimenez et al., 2010; Longworth, Ratcliffe, & Boulton, 2001; O'Cathain et al, 2001; Overgaard, Fenger-Gron, & Sandall, 2012; Schmied et al., 2009; Sutcliffe et al., 2012). The relationship between these concepts and satisfaction appear to be strongly associated with one another, but maternity care is a multidimensional concept that can be influenced by a variety of other factors, including prior experiences and perceptions (Christiaens & Bracke, 2007).

In a cross-country assessment of childbirth satisfaction for Dutch and Belgian women, perceived pain was less of a factor of satisfaction overall when compared to other aspects investigated, which included control over the birthing experience, self-efficacy, and fulfillment of expectations. Christiaens and Bracke (2007) suggest that there is a stronger connection between personal control and satisfaction than any other determinant, even in the absence of fulfilled expectations. While the findings in this study are only applicable to these regions, the researchers note that the outcomes may have a more general meaning across other groups due to the variance in maternity care systems the two counties exhibit. Christiaens and Bracke (2007) recommend other professionals examine the findings cross-nationally for verification.

The Military Healthcare System

The Military Healthcare System (MHS) is one of the largest and longest running healthcare platforms within the United States (Granger et al., 2010). Under the direction of the Department of Defense (DoD), the MHS is responsible for providing upstanding, quality, care to beneficiaries across the globe (Jacobson & Jensen, 2011). The civilian and military healthcare industries both face some of the same obstacles universally, but demographically and geographically diverse patients, who are also highly mobile, present

the MHS with greater challenges in delivering accessible and satisfactory care (Granger et al., 2010). In response to these unique circumstances, the MHS has implemented a variety of quality assurance (QA) assessments, with the goal of improving health programs, structural organization, and overall care.

The transformation of the MHS is extensive and dates back all the way to 1799, when the first legislative decree was enacted by Congress, requiring sick or disabled military members to be relived of immediate duty (Granger et al., 2010). Since then, the evolution of care, services, eligible beneficiaries, and accessibility has expended greatly, but two of the most successful implementations have been the development of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and its successor, TRICARE (Granger et al., 2010; Jacobson & Jensen, 2011). Through these programs, the Armed Forces have been able to directly oversee QA for purchased care (PC) and direct care (DC) throughout the military. Today, evaluations within the military population are collected through various standardized survey instruments and are distributed on varying timelines. The goals of these investigations are to measure beneficiary and staff satisfaction, so that TRICARE may be able to improve quality care, patient access, and further strategic planning (TRICARE, 2014). There are a multitude of evaluations used to assess various aspects of care, such as overall consumer satisfaction, out-patient services, and health plans, but the focus of this section is the level of satisfaction with in-patient care, as it incorporates maternity services received during labor and delivery (LD).

The in-patient satisfaction survey, also known as the TRISS, is used to evaluate and report on the experiences of adult beneficiaries who received direct care (DC)

through the MHS' military treatment facilities (MTF) or purchased care (PC) through civilian networks and hospitals (TRICARE, 2012). The term experience is used throughout the report to represent several components of health, but does not qualitatively speak for participants' views. The state of in-patient care within the MHS is satisfactory, with the majority of components rated above national benchmarks, but overall hospital rating and a patient's willingness to recommend the hospital received significantly less than acceptable ratings in most areas when compared to national averages found in the civilian benchmark HCAHPS (Appendix F). The data suggest that patients are satisfied with the majority of aspects evaluated in the TRISS, and even note high ratings for hospital cleanliness and quite environment, yet participants overwhelmingly suggested that they would not recommend the hospital and that overall ratings were subpar (TRICARE, 2012). As proposed by Sofaer and Firminger (2005), patient satisfaction surveys make it near impossible to determine if participants believe that the services received were merely acceptable or outstanding, thus causing the data to be misleading. The TRISS research supports this idea. Based on the data, an overwhelming majority of patients are satisfied with the care received, but they would not advocate for the use of the facilities to family and friends. There is a strong disconnect between these two findings, which implies that patients may be satisfied, but that the level of satisfaction is not what it should be. Conversely, there may be other important factors of care that are not addressed within the survey, such as patient control, the ability to used informed decisions, or levels of support, that need to be investigated. Standardized surveys may be a cost-effective way to reach a much larger target

population, but the data do not represent the full scope of satisfaction as experienced and perceived by patients.

There is a significant lack of current, independent, and qualitative research within this particular area that requires a reevaluation of the issues. Research has shown that there are a multitude of determinants that can affect patient satisfaction with maternity care, but military members may face additional obstacles that could also play a role in the perceived quality of care, including deployments and social support (Hass, Pazdernik, & Olsen, 2005). Hass et al. (2005) found that women with deployed spouses presented with significantly higher levels of stress and various harmful affects on their health. This finding was also consistent for mothers who had more than one child at home. One in five women who were evaluated also reported having no other support person. Lack of support could also affect self-efficacy, which can in turn influence patient satisfaction (Christiaens & Bracke, 2007; Hass et al., 2005).

Based on the literature, the purpose of this study was to understand the experiences and expectation of LD hospital care for mothers who had recently given birth as an active duty member, or dependent, in the MHS, as well as establish which factors were associated with a positive or negative experience. Exploring data under current policies has the potential to increase satisfaction within the MHS, improve overall healthcare experiences, and can also be applied to future changes in practice and delivery of care.

Grounded Theory

Within the medical community there is a significant lack of adequate theories to explain the meaning of patient satisfaction (PS). This is thought to be the result a general

lack of definition; because of this, developing sufficient patient satisfaction surveys, or interview questions, can become problematic (Baker, 1997; Department of Health and Aging, 2006; Redshaw, 2008; Sawyer et al., 2013). Like many psychological concepts, satisfaction is easy to comprehend, but difficult to define (Orgev & Bekar, 2013). Despite an increase in the number of PS investigations globally, there remains a lack of a fully developed theory (Department of Health and Aging, 2006). The majority of patient satisfaction models were created in the early 1980s, before patient centered care became the focus of hospitals, doctors, and executives; a few principle theories are still used today for quantitative purposes, but do not align well with qualitative methods due to their statistical nature (Department of Health and Aging, 2006). Brady (1998) notes that very little is known about this phenomenon in general and no previous researchers have used qualitative methods to investigate women's perceptions about military maternity care and satisfaction.

While this study is not specifically looking at satisfaction, rather the labor and delivery process as a whole, it must be stated and understood that the phenomenon of satisfaction is an underlying component and product of experiences and expectations. In order to understand how to improve the system, it must be investigated as to why patients are not satisfied and then try to create a theory that explains the process, which comes from experiences and expectations that may play a role in overall satisfaction. Discrepancy theory (DT), which states that a patient's satisfaction can be "determined by the differences between what is expected and what actually happens" (Sawyer et al., 2013, p. 2), is therefore a proper fit for this investigation. In addition, the theoretical model of quality of care (Wilde et al., 1993) notes that a patient's perception of "what

constitutes [as] quality of care are formed by their encounters with existing care structure and by their norms, expectations and experiences" (Wilde-Larsson et al, 2009). It is important to note that perception and satisfaction are two distinct concepts, however they are not mutually exclusive. According to Orgen and Bekar (2013), levels of satisfaction are dependent on the experience of services only after being received, but that the perception of care can occur during any stage of the process, whether that is pre- or post-hospital stay. Since perception can directly impact a patient's views before care has taken place, an evaluation of these influences is needed to form a larger view of patient satisfaction as a whole (Orgen and Bekar, 2013).

Discrepancy theory (DT) is not a new model, but is a relatively novel idea in the healthcare community and has not been widely used (Knight, Cheng, & Lee, 2010; Mahomed, St. John, & Patterson 2010). The origins of DT are rooted in the industry market, where consumer satisfaction was determined by measuring the difference between expected outcomes and experiences with the product (Newsome & Wright, 1999). Problems with this line of thought are that most patients do not view their care as a purchased product, but rather a system of relationships with doctors, nurses, and hospitals. While expectations do in fact play a role on the outcome of satisfaction, they are not a major driver of it in all situations (Mahomed et al., 2010), and thus why it is important to also look at the experiences of the patient. Mahomad et al. (2010) note that differences in satisfaction can be seen when a patient's personal experiences and beliefs about an occurrence are met or excused. For example, if a patient expected to be seen by a doctor within a certain amount of time, but was kept waiting for a significantly longer period, they may still note the experience as satisfactory if the doctor's tardiness was met

with an acceptable excuse. Linder-Pelz (as sited by Mahomad et al., 2010), who was the first to use the DT in the healthcare setting, noted that patients had a significantly higher satisfaction rate when their expectations and experiences were both positive. Conversely, patients who had less than favorable expectations and experiences were less satisfied. Those who had favorable expectations, but negative experiences varied, and have thus lead other researchers to concluded that expectations alone do not determine satisfaction, but rather, it is a combination of experiences and expectations. Using DT will allow for an in-depth investigation of patterns or common themes that may affect satisfaction and dissatisfaction, as well as patients' previous experiences and expectations before being admitted for labor and deliver within the MHS.

To fully understand women's perceptions and experiences with military maternity care, grounded theory (GT) was applied to this investigation. According to Munhall and Boyd (1993), qualitative research designs allow for more in-depth explorations of a phenomenon and give the researcher an opportunity to examine participant's experiences as a whole. For this particular area of research, this could inevitably lead to the enhancement of the quality of prenatal care received within the MHS (Brady, 1998).

Through GT researchers are able to gather, interpret, and share the stories of women who have gone through the process and are able to communicate their opinions and perceptions. In addition, common themes can be uncovered and linked to overall feelings of satisfactory or unsatisfactory views of maternity care (Clandinin, 2006; Pope, Ziebland, & Mays, 2000). In this study primary data was collected through semi-structured interviews, which allowed for participants to explain why certain areas of care were not satisfactory. The following chapters describe the research methods used to

collect data (Chapter 3), the results (Chapter 4), and an analysis of what the outcomes reveal, how to further future investigations, and overall conclusions (Chapter 5).

Chapter 3: Research Methods

Qualitative research methods involve the use of observations, interviews, documents, and/or audio-visual materials to gather and interpret data collected throughout the investigative process. These data are non-numerical and are traditionally used to explore and understand social or human problems (Creswell, 2009). A qualitative study was selected for this investigation using grounded theory (GT). A GT approach was chosen because it allowed for an in-depth exploration and development of the concept through interviews (Clandinin, 2006). The purpose of the research was to understand the experiences and expectations of women that gave birth within the MHS, and to analyze the patterns of common themes among participants. Data was used in an attempt to create a new theory grounded in the findings (Creswell, 2013; Fitzpatrick & Boulton, 1994). This specific approach more closely aligned with the overall research proposal than any other, because the experiences were more recent, rather than over an extended period of time (phenomenological), and the identification of cultural patterns was not being explored (ethnography) (Creswell, 2013; Munhall and Boyd, 1993).

Research Design and Approach

Primary data was collected through one-on-one semistructured interviews via Skype or FaceTime and included a preset list of open-ended questions (Appendix G) to help facilitate the discussion. Using a grounded theory hermeneutical approach, the research questions evolved and changed over time to ensure the researcher was asking the best questions. All data was audio recorded, and hand written notes were entered in a journal. It has been noted that unstructured interviews are more appropriate for subject matter that is complex and relatively unexplored (Fitzpatrick & Boulton, 1994).

However, the area of interest is not very broad, and a preselected list of questions (Appendix G) helped guide the beginning of discussion. One-on-one interviews are generally flexible in nature, which allowed the researcher to adapt approaches with each participant interviewed (Creswell, 2009). As data was being collected, I simultaneously coded, analyzed, compared, and redefined emerging categories till they had taken an abstract form (Fagerskiold, Wahlberg, & Ek, 2001; Turner, 2010). Demographic data was also analyzed concurrently with each interview.

I was the primary contact and the sole instrument for contacting participants. All data was collected via Skype or FaceTime interviews. Only I interpreted, and analyzed the data.

Potential participants were contacted through an unofficial military base affiliated family and spouses Facebook page in the Midwest region. Due to confidentiality restrictions, the name of the page, the location of the base, and the names of the hospitals have been removed from this document. I also accepted participants who learned of the research by word-of-mouth. The group used is a private association that is only open to current members of the local military base and previous residents who wish to continue to be a support to the community. I posted information about the study on the page, explaining the study, calling for participants, and including contact information. A note was also added to include that the study was completely confidential, and that knowledge of an individual's involvement was limited to the best of the researcher's ability. Potential participants were asked to contact me through email only, as that was the best way to ensure privacy. A separate email account was set up solely for the purposes of this research project, and will be inactivated 5 years after the study. Since the group Facebook

page used is relatively small (N = 1,200), all participants who met the criteria were included until saturation was reached.

Once a participant contacted the researcher with an interest to be included in the research study, a qualification email was sent along with the consent form (Appendix H). Contained in the consent form was statement addressing the participants' rights, including the ability to withdraw at any time without repercussion or further inclusion.

To safeguard the wellbeing of the participants, several ethical procedures were implemented as noted by the American Psychological Association (2010). To protect individuals' privacy, all participants were assigned a number reference for their case; this ensured that no names were associated with the study, and no connections to the individual could be made when analyzing the raw data. A completely separate and secure document was created to allow for the identification and deletion of participants who wish to withdraw from the study. Secondly, consent forms were emailed prior to survey participation, and ample time was given for questioning before interviews. All physical files were kept in a locked file cabinet, and all electronic files were stored on a password encrypted external hard drive. Before commencing with any interviews or interactions with participants, all procedures were submitted to and approved by the Institutional Review Board of Walden University (Approval number 09-09-15-0289136), for safety and ethics.

Setting and Sample

A convenience sample of participants was elected from the Facebook group. Women included in the study were identified as meeting the following criteria:

- A significant other/spouse of an active duty member, or an active duty member herself
- Used either TRICARE standard/prime
- Possessed no other form of health insurance
- Was between the ages of 18 – 40
- Delivered while stationed at the local military base (name hidden for confidentiality reasons)
- Had a self-reported uncomplicated pregnancy, with no outside medical factors affecting a need for additional special care
- Delivered a full term baby, as defined by Spong (2013) and Fleischman, Oinuma, and Clark (2010) (37 weeks 0 days through to 41 weeks 6 days).

Since relocation is a highly common practice within the military, it was anticipated that some women would not be able to participate due to delivering at a different location.

Selection criteria also included date of delivery. Memory decay can be an influential factor that affects the accuracy and quantity of information provided, but there is conflicting data on the best timeframe for the recall of healthcare services received (Bhandari & Wagner, 2006). Underreporting was found to be higher as participants neared the 12-month mark, but this outcome was more closely associated with the number of visits. As the number of appointments increased, so did the frequency in underreporting. The labor and delivery process is considered a highly impressionable event, which is less likely to be affected by this factor (Bhandarin & Wagner, 2006).

Research has found that the accuracy for recall of self-reported events is generally higher for in-patient visits when compared to outpatient appointments, or when the services received were memorable (Ungar & Coyte, 1998). Analysis of various memory recall studies shows that the accuracy for services like maternity care can be considered relatively significant up to 12 months, with the optimal recall period being 6 months or less (Bhandari & Wagner, 2006). It would have been ideal to limit participants to due dates within a 6 month time frame, however, due to the relatively small population, women with due dates up to 12-months were considered for inclusion. The cutoff date reflected a 12-month time span, with the endpoint coinciding with the date of the scheduled interview.

Sufficient sample sizes in qualitative research can vary based on methodological approach, study design, and the question the researcher is attempting to answer (Mason, 2010). However, Mason (2010) noted that qualitative samples should seek to obtain enough participants that most or all of the perceptions within the study are uncovered, but small enough that the data do not become repetitive. In an analysis of numerous grounded theory (GT) investigations, Mason (2010) found the average number of participants to be 32, with a mode of 25 and median of 30. Creswell (2013) noted that GT studies typically include anywhere from 20-60 participants, but recommends 20-30 in order to develop a theory that is well grounded and not oversaturated. Based on those recommendations, the goal sample size was 25, but was less due to the number of women who did not meet the inclusion criteria.

Data Collection and Analysis

Data was first transcribed into statements from the interviews. It was then organized and coded based on specific key words and themes that arose. An Excel sheet was also created and bulk statements keys as positive, negative, or neutral were added across the x-axis. From here, generalizations about this specific population were made. TRICARE (2013b) yearly evaluations ask women to rate specific factors and their satisfaction levels. Some of these same themes arose within the investigation, but there was no clear way to compare the data collected through TRICARE (2013b). Qualitative research has been left out of military patient satisfaction surveys, but enhances the knowledge already held by the research community.

Research Trustworthiness

In order to verify trustworthiness of the data, several techniques, as described by Lincoln and Guba (1985), were used, and included:

- *Thick description*. Study's participants, context, and procedures were presented in sufficient detail to allow independent researchers to confirm that findings of a study are believable and the methods are dependable, and enable others to determine the transferability of the results to specific contexts.
- *Audit trail*. Includes raw records (e.g., tape recordings field notes), analysis records and products (e.g., summaries, working hypotheses), synthesis records and reconstructions (e.g., literature reviews, final reports, categories), process notes (e.g., procedures, designs, rationales), and instrument development notes (e.g., pilot instruments, revisions). The audit trail also provides documentation of

procedures and permits determination of the dependability and conformability of findings.

- *Member checking with committee.* Member checking occurred in various ways throughout a qualitative study. Key informants were central to the member checking process as the researcher returned to them for explanations and checks on interpretation.
- *Reflexive journal* (Appendix I). Researcher maintained ongoing records (personal notes) that document their thinking throughout the research process (e.g., reactions to participants, personal interpretations, links to prior experiences (Lincoln & Guba, 1995).

Reflection of Personal Biases

As a researcher, it is important to understand one's own biases and how to avoid bringing them into a study (Creswell, 2013). As a former military wife, who has also gone thorough the TRICARE system, I am prone to my own biases. These can arise from my own experiences with medical treatment, stories that I have heard about from others, or my extensive review of the literature. In order to avoid these within the research, it would be beneficial to reflect on my ideals, personal feelings, and thoughts about the matter. In addition, having my committee peer review all of my interview questions for leading or biasness would be beneficial (Rajendran, 2001).

Upon reflection, I do have a strong interest in the topic, personal experiences, and biases that could have played a role in the research outcomes. I personally had no issues with my maternity care, but I have also known others who have had unfortunate experiences with theirs. I am competent in my ability, and that I was able to leave these

particular feeling out of the research, due to my understanding that individual experiences can be affected by a variety of factors. I do have stronger biases towards some of the common themes that affect maternity care. These developed as result of my extensive literature review analyses. When researchers allow their predetermined biases and expectations to guide the research, important themes within data can be missed. It can also lead to confirmation bias, in which the researcher seeks to validate their expectations with information that is consistent with their own views (Pope, 1998). To detour this effect, it is essential to explicitly define one's own biases and to be transparent with their views. My main bias was with the factors that affected patient satisfaction. Many common themes emerged from the literature and made an impression on my views. I believed these topics would also be found in my own research, with the most important being personal control over the birthing process. I have been fully aware of this bias and used thick description to ensure that I was analyzing the data neutrally.

The following chapters communicate the results and summary of the data. The results (Chapter 4) include large sections of conversational transcriptions focused around the main themes unveiled throughout the analysis phase of the study, and the summary (Chapter 5) divulges into what the data show, how the medical community can further the future of research in this area, and what this means for social change.

Chapter 4: Results

Yearly patient satisfaction surveys conducted by TRICARE (Appendix A) show that mothers who have recently given birth within the MHS are overwhelmingly satisfied with individualized factors of care, but would not recommend the hospital to family or friends. This finding suggests there could be additional factors of care that may lead women to rate the hospital less than satisfactory. The focus of this study was to understand women's experiences and expectations to potentially discover underlying or additional factors that may lead to patient satisfaction with labor and delivery (LD) care.

Women who have recently given birth within the MHS were interviewed and participants provided details concerning their experiences, expectations, and perceptions. While mothers were asked to discuss their most recent experience, conversations about past encounters arose. These were found to have an effect on expectations of their current labor and delivery, as well as their choices for care and how they received it. In this chapter I describe the processes and procedures of recruitment, demographics, overall results, and how data were gathered, stored, and analyzed.

Recruitment

Beginning in September 2015, participants were recruited through an unofficial military base affiliated family and spouses Facebook page in the Midwest region. Due to confidentiality restrictions, the name of the page, the location of the base, and the names of the hospitals have been removed from this document. The site boasts a largely active community of over 1,200 members, and serves as the community's networking and communications hub for the local base. Announcements were made on the site's page (September 17, 2015, October 2, 2015, December 14, 2015, February 15, 2016, February

25, 2016), calling for mothers who had recently given birth while stationed at the local base and were interested in participating in a graduate research study. All respondents were asked to provide their email or to email the researcher. Initial contact with potential participants provided them with the following list of qualifiers:

1. Are you between the ages of 18-40?
2. Are you a dependent of an active duty service member or an active duty member?
3. Did you only use TRICARE standard or prime? (Meaning no outside insurances)
4. Did you deliver while stationed at [the local base]?
5. Did you have an uncomplicated pregnancy?
6. Did you deliver a full term baby (37 weeks 0 days - 41 weeks 6 days)?
7. Is English your primary language?
8. As of today's date, did you deliver within the last year?

Potential participants were encouraged to ask questions about the qualifiers if they did not understand, or needed clarification on the criteria. The most commonly questioned qualifier was *Did you have an uncomplicated pregnancy?* This criterion was included to identify mothers who may have needed additional treatment that is outside of typical labor and delivery processes, such as additional fetal monitoring or high-risk pregnancies that required constant observations. These additional services have the potential to impact patients' views on typical labor and delivery procedures and were excluded from participation.

During the earlier phases of recruitment, some limiting factors were found to

contribute to the misunderstanding of qualifications or were limiting the number of participants who met all criteria. In order to resolve the issues, an amendment was sent to Walden University's IRB requesting approval for the following changes, which as approved: Skype or FaceTime for interviews, a target of 12 participants, and changed wording from 37-41 weeks to 37 weeks 0 days through 41 weeks 6 days.

In total there were 30 respondents: 20 meet all criteria, nine did not, and one was not interested in participating after learning more. Once eligibility was determined, potential participants were sent the consent form (Appendix H) and a range of dates and times were given to schedule a one-on-one interview. Of the 20 qualifying individuals, 15 scheduled interviews, while five did not respond. Follow up emails were sent to the five remaining qualified individuals, but no replies were received. A total of 12 interviews were conducted (three did not show).

Data Collection and Storage

Each participant was interviewed via Skype or FaceTime and video and voice recorded. Video recordings were made possible by the program QuickTime, and a handheld digital voice recorder taped voice recordings. At the beginning of each interview, participants were given a brief synopsis of what to expect. I informed the participant that I would (a) be asking for consent to participate and record, (b) explain the research, (c) ask some basic demographic questions, and (d) have an open conversation about their birth experience. Once recordings started, participants were asked to confirm they received the consent form and consented, and if permission was given to record. Each video and voice recording was saved on a password protected external hard drive and labeled with a non-identifying participant ID number, which was given to individuals

when they scheduled their interview sessions. All participants were given an alphanumerical ID (A1-A15) to use in reference if they ever wanted to remove their information from the study. Handwritten notes were kept in two separate journals. Journal 1 consisted of names, qualifiers, checklists, and notes about the respondents. Journal 2 contained handwritten notes from all interview sessions and thoughts about possible emerging themes; both journals were kept in a locked safe in the researcher's home office. Each interview was transcribed in Journal 2 and in Excel. The Excel document was also stored on the password protected external hard drive.

Participant Demographics

The local base has primarily Air Force personnel, but is one of nine of the United States' Strategic Command Centers and supports all branches of the military. Although it was believed this would create diversity in the sample, all but one participant was affiliated with the Air Force. Participant demographics can be seen in Table 1.

Table 1

Participant Characteristics

Characteristic	Number	Characteristic	Number
Age		**Insurance Type**	
18-20	0	Standard	5
21-25	2	Prime	7
26-30	6	Pink Team	4
31-35	3	Blue Team	2
36-40	1		
40+	0	**Rank**	
		Officer	4
Weeks at Delivery		Enlisted	8
37	1		
38	1	**Service**	
39	6	Air Force	11
40	1	Army	1
41	2		
Missing	1	**Description of Hospital**	

(table continues)

Missing	1	**Description of Hospital**	
		8	1
Number of Previous Deliveries		9	6
0	5	10	5
1	4		
2	3		
Type of Delivery			
Cesarean Section	3		
Vaginal	7		
Missing	2		
Midwife			
Yes	3		
No	9		

Data Analysis

Data analysis began by organizing the information into an Excel document. The participant's identifier was put in column one, with demographics and interview details in the following columns. Columns were labeled with the following headers: Participant number (A1-A15), active duty or dependent, branch, officer or enlisted, age, number of previous deliveries, number of weeks delivered at, prime or standard, place of delivery (hospital name), type of delivery (vaginal or cesarean section), hospital rating (1-10), would they recommend the hospital (yes or no), midwife (yes or no), birth plan (yes or no), positive comments/experiences, negative comments/experiences, neutral comments/experiences, and additional notes. Data were entered into each column by rereading written notes from Journal 2 and watching the recorded interviews. This initial step allowed for a broad overview of demographics and important notes. Next, all interviews were transcribed through the free application Transcribe. All transcriptions were saved in their own word document and stored with the participant's other files.

After transcription was complete, the program Annotations was used to code statements and analyze broad themes, which are detailed in the following section.

A Microsoft Word document was also created to include notes, thoughts, and emerging themes I perceived throughout the process and included notes from Journal 2 (Appendix I). This was done to ascertain whether these beliefs remained or shifted by the end of the study.

Themes Identified

Few evaluations have qualitatively focused on understanding a woman's experiences and overall expectations of treatment during labor and delivery (LD) hospital stays (Harriott et al., 2005). Harriott et al. (2005) were the last researchers to investigate the potential factors that affected care by looking at the satisfaction levels of women within the Military Healthcare Sysytem (MHS) and which phenomena were associated with a woman's likelihood of recommending the medical treatment facility for LD. They found that most of the factors assessed were important in determining if women would recommend the hospital in which they delivered, but that over half of the patients were not satisfied with the care they received. Their findings were the first of their kind, but no further research has explored these concepts since then. A continuation of significantly below average ratings on the yearly TRICARE satisfaction survey (TRICARE, 2012) indicates that some areas are being unexplored.

The purpose of this study was to qualitatively explore women's lived experiences with their LD hospital stays, to understand what expectations they may have had prior to delivery, and what, if any, were the inconsistencies between their expectations and their experiences.

The following themes show an overwhelming support for the idea that expectations may not play as meaningful a role as prior experiences do. Additionally, prior experiences with pregnancy were found to have an impact on decisions concerning the current pregnancy and LD choices. When participants had zero previous births, they had nothing to compare their birth to. Woman who had one previous birth tended to describe their experience as less than great if it did not meet their expectation when compared to their previous experience. However, if they had a better experience with the current delivery, they tended to describe the overall experience as more favorable. Those with two previous births appeared to know exactly what to expect and were prepared; meaning everything went according to the way they expected and prepared for.

The data also showed that there was an unusually large amount of comments made towards prenatal care, even when the focus was on labor and delivery. Many women stated that their issues were not with the labor and delivery process itself, but rather aspects of care received through the base (prime care). Women who selected standard care, more often than not, had previous issues with prime care and chose to switch to standard care in order to be able to see the doctor or midwife of their choice.

Theme 1: Issues with Base Provided Prenatal Care

All maternity services were delivered through either TRICARE prime or standard for each participant in this study. TRICARE standard allows beneficiaries to chose any in- or out- of network provider for a monthly fee and a small deductible; once the deductible is met, all services (in-network) are covered 100%. TRICARE prime has no fees and no deductibles; however, the beneficiary has little to no say in their primary care manager (PCM), specialists, or any other physician services unless they live outside of

the base hospital/clinic radius. In this unusual case, prime members may choose their own in-network doctor. All beneficiaries in this study lived within the base hospital radius and were required to use base amenities if they chose to stay on prime. The base's prime prenatal care offers two options: the pink team or the blue team. Each team is comprised of multiple doctors, who have varying schedules, but the blue team is resident heavy.

Despite participants being asked to talk about their labor and deliver experience, prenatal care often came up during the discussion. Because of this, prenatal care was later incorporated into the interview sessions. Interestingly, almost all participants who used prime care voiced some type of concern with the way they were treated, or with the doctors in general. Some of the participants noted that they didn't "...get information unless we ask for it," or that some of the doctors were "pushy" about subjects such as breastfeeding and birth control options after birth. One major concern was the feeling of being rushed, or dismissed, during routine appointments:

> A3: Some days I felt like I was just kind of herded in and out, let's measure you, and make sure you're ok, and get you on your way. I don't know if it was because it was my second pregnancy, and they thought that I knew what I was doing, but my second one was completely different than my first one. Completely different, so I had a lot of questions and some of the doctors, I felt like [they were] annoyed almost [and I was] taking too much time.

> A8: The only thing that I did not like was that when I would ask certain questions about the third trimester, and let's say I was in the first or second, and when we would start doing certain things, when we would start testing, or x, y, and z, they told me, instead of answering the questions, they just said don't worry about that yet. I understand that they didn't want me to be dwelling that are not now, but I wanted the knowledge so perhaps I felt that they were just dismissing me, but other than that they were all fantastic.

> A14: You know sometimes I felt like I would ask questions, and maybe I was just asking dumb, first-time mom questions, but I felt like I never really got answers

> to some. Like, about my weight gain. I didn't gain any weight until the very very end, and then suddenly I put on 20 pounds in like a month and I was like really upset about this and I was telling them oh my god this is a problem, and they were like "don't worry about it". You know it's nothing [big], but that is the only response I got, no you're fine. I don't know, I guess I just wanted to talk about it more or something

Other issues women faced with the pink and blue teams were a lack of connection, cohesion, and a lack of control or voice when it came to birth issues that were important to them. One participant noted having to argue with doctors about not having any unnecessary interventions. She stated “They bounced me around the OB practice for the last 6-8 weeks of my first pregnancy so I saw different providers who wanted different things and who wanted to induce me early and all sorts of other things, so lots of interventions that I had to argue not to have”.

Some women found they connected, or liked, one doctor more than another and chose to schedule their prenatal appointments based on that particular doctor’s work schedule. When participants were able to gain a report with one of the team’s doctors, their comments about care were more positive overall. When participant A1 was asked about her experiences with the blue team, she stated, “I was kind of nervous, I didn't understand the concept of resident doctors”, but that her connection with one doctor in particular really made her feel comfortable with her care.

> A1: We are LDS [Latter-Day Saints], and the doctor we were seeing happened to be LDS, so we shared religious views, so it was comforting on that level. [He was] very willing to listen to what we wanted and work with us on what we wanted. We walked in feeling like we understood each other because of our faith and it was a great way to start the doctor-patient relationship.

Theme 2: Expectations, Experiences, and Perceptions of Care are Multifaceted

Whether participants expressed their expectations as high, medium, or low, and regardless of complications, participants' overall views of the labor and delivery process were generally favorable.

All individuals who had had 0 previous births rated their experience as a 9 or above. Interestingly, all who gave below a 10 said they would have rated it a 10, except for either one minor issue, because they did not know if they should rate it a 10 without having prior experience, or because they do not believe in absolutes. Out of the 12 interviewed participants, 5 had 0 previous births.

Participant A1 states that she had very high expectations, as outlined in her birth plan, but her expectations were not met. When asked if everything went according to her plan, her response was "No, well, yes and no. We were really blessed that we wanted to do it naturally and I feel like for the most part we did that, and so that's what I wanted and that's what we got". In discussing with her further, her birth included intricate details about the hospital conditions, staff, and noise levels.

> [We] wrote a very detailed birth plan and most of it centered around a very serene, hypno-birthing, and that is mostly what changed as far as the plans. I even requested that I didn't want any students comings, only necessary medical staff coming in, I only wanted them there when they needed to be. But from transition on I was pretty vocal with labor and so I felt a little hypocritical because I had even printed out a sign for the door that explained it was a hypno-birthing room and that I wanted it quiet.

Although she states that not much went according to plan, she was overall "really impressed" and mentioned that the hospital and staff exceeded her expectations. Participant A1 notes "I think there was a lot that I didn't even think of that they did that was really thoughtful... the whole time [we] were just in awe of the service of pretty

much everyone, even just the lady that came in to clean up the room a little bit". After reflecting on the overall birthing experience, participant A1 said she would definitely recommend the hospital to family and friends, but would only rate it a 9.5 because she "usually try[s] not to be too absolute and rate things a 10".

Participant A13 also went in with higher expectations, as well as a birth plan, although she states it was more of a lose one.

> I didn't want any pain medication, no epidurals. I wanted to be able to kind of decide in the moment if I wanted to walk around ... I wanted a little bit of freedom of movement. I wanted to be able to eat if I wanted to or drink. I also wanted as few interventions as possible. And that was pretty much everything that I had on the birth plan.

When asked if she felt like her expectations were met, and how well she felt she was able to stick to her birth plan, A13 noted "I did completely. The only unexpected thing was the Foley balloon that they did. When they inserted that I was already a cm dilated, so that kind of kick started everything that was already happening, so outside of that everything else happened exactly the way I wanted it to". Overall, her expectations were met, except for being able to deliver at the midwife center. Participant A13 notes that her satisfaction with the experience was directly linked to her own expectations and not anything that anyone else did:

> Everything was really easy, really smooth; I didn't have any complications or troubles. I was greatly satisfied and it was about what was expected. I think really the only thing not giving it a 10 was my expectations, because I did want to and expected to be at the midwife center, and really the only thing I didn't prepare myself for was having to be induced and him not coming. ... it never crossed my mind that he just wouldn't come out. So that really is the only reason it wasn't a full 10, but that's all related to my own preferences, and not anything that anyone else did.

Participant A4's expectations were relatively low. She notes that she was very open to the

experience and did not let stress affect her; “How I look at it is my age, I'm pretty, I mean, I was 35 at the time and I already had nieces and nephews and I was pretty.... Nothing goes according to plan, whatever you want, so I was more laid back, open.” During the discussion A4 revealed that she did have a few complications during her pregnancy, such as her placenta bursting internally and not being able to have an epidural like she expected, but that she would still describe her overall experience as a 10. She notes

> I thought I would have an epidural. I didn't think I would feel it. I do think that all my friends who did natural, that was their choice. I didn't have a choice, but that's something you can’t control and I’m glad that I didn't have a game plan.

Participant A8, like A4, also expressed having low expectations, but experienced complications during the pregnancy; however she also described her experience as “very well”. She explains “...my only expectation was that I was going to be able to get the epidural before I had to start pushing and like that almost didn't happen, and I had to feel what it really feels like to push a baby out without the epidural, so no, it didn’t go according to my expectation. It's fine though because I asked for a popsicle and I at least got that, so it was fine.” Despite having to labor through the birthing pains for an hour and having to labor an additional 25 to remove the placenta, A8 states that the hospital doctors, nurses, and staff were “fantastic” and that “I would give them a 9 because the resident sent me home, when I was 6cm. That is the only thing. Ugh! My contractions never came consistently though, and I had to tell them that they never came close, but how would I know, I had never done it before. So I didn't know what to expect”.

Participant A14 stated that she had low expectations and ended up having to undergo a C-section, but still described her labor and delivery experience as “great.”

According to A14, she did not feel confident enough to give the process a 10 because she did not have any prior experience with labor and delivery: “I don't have anything to compare it to. I guess I would, I mean, having no expectations going in, I would probably put it at like a 9. I thought it was great”. With regards to expectations, the participant stated, “I don't think I had any expectations at all. I had no idea what was going to happen. So it worked out well. I mean I was hoping to be able to deliver vaginally, and that didn't happen, and that's ok.” When asked if she had any other expectations going into labor and delivery, A13 noted, “Well, we had never done it before, so our only goal was to have a baby.” One important note that was made during this interview was the participant forgave a lot of the doctors and nurses behaviors, such as rushed appointments, having her question put off, and having to explain her history each time she saw a new doctor. In explaining this, she said “I know that they have a lot of patients to see and just like any other doctor, they are not just going to spend 30 minutes with every person that comes in there. I know they are very busy.” In addition, she notes that the really does not have the right to complain: “I mean, it is a free service, bottom line, I am not going to complain. If I was paying $100 an appointment, maybe I would be annoyed, but you know I can't complain about it especially for what it is.”

Women who had 2 previous births were the most confident in their birthing decisions, and all had chosen to go with standard for their care needs. Each was overwhelmingly happy with their decisions and had a level of self-confidence that was exuded through their mannerisms and their statements. Participants with 2+ births also noted being influenced by their past experiences and having particular expectations based upon their knowledge of their bodies, the process, and general expectations.

Participants A9 and A11 both discussed complications with their first that lead them to switch and choose the doctor they wanted to see. “My first pregnancy was a stillborn,” noted A9, “It [the base OB] was a young guy, he wasn't bad or anything, I am not trying to talk bad about him, but I just don't think he had a lot of experience.” For participant A11, she explains that her base OB provider did not give her the type of experience they were looking for and also betrayed her trust. She said “My first birth was not horrible, in that I mean it definitely could have been worse overall pretty good, ... but my doctor in the delivery room kind of panicked, which I later found out about wasn't an issue, and she had us pretty much, from the time we arrived, had us thinking our baby was going to die, and it turned out it was nothing. She apparently thought it was fine too, but never relayed that information to us, so my husband and I spent the entire 45 minutes of me pushing like a mad woman to get my baby out to try and save her life.” Participant A11 explained that they believe this was because it was Christmas week and the doctor did not really want to be there, “She came in in her sweatpants, I think she was just in a hurry to get home, and she knew I was a first time mom, and I wanted to push when I felt like I needed to push and do so at my own level of comfort, and that was going to take longer, than me pushing like a crazy person”.

When asked about expectations going into labor and delivery for this pregnancy, participants noted having a feeling of comfort because they knew the provider well and felt at ease with them and the process. A9 stated, “I kind of already knew what to expect since I was going back to the same person, so I could go to the same place, so I knew the routine. I loved it, and I had a great experience with it, and I had no problems whatsoever.” Similarly, A11 said “I knew this provider just, even in talking to

her prenatally, was still going to do everything she could to try and make it the best experience possible for me, ...and I knew that she was honest when she said 'I am going to do what I can to make this experience as enjoyable for you, given the circumstances, that I can.'". Participant 15 noted this experience as the "Best one out of my three total".

Participants who had only one prior birth varied in their stated and non-stated expectations, experiences, and perceptions of care. Of the four participants with one previous birthing experience, only one described her perception of care as mediocre. As she explains, "It wasn't bad. If I had to do it over again I would have asked and made sure I was better prepared." In this particular participant's experiences, her first labor and delivery greatly differed from her second, and she believed it had an effect on her perceptions of care.

> They ... [closed] me up, put her on my chest, wheeled me to my room and left me in the room. I couldn't feel anything from my armpits down, and I had a baby to take care of, and no one there. I found it very odd that they didn't have a nursery. I don't know if that was a normal thing here. When I had my daughter, we were civilian, and they asked me if I wanted her to stay with me, or if I wanted her to go to the nursery, they took her to the nursery. When I wanted her they would bring her back in. I got to sleep and rest and recoup. Nothing. My daughter stayed with me the entire time.

When asked specifically about having expectations going into her second delivery, participant A3 stated, "Yes, I did. Like I said, I expected them give me the face to face time and the skin to skin contact while they were sewing me up, because that is what I did with my daughter, and then I thought they would take her to the nursery and let me get some rest since I was doped up "so to speak." I did expect that, and I guess I should have asked what the procedure was so I would have been a little more informed, but I don't know." Overall, A3 was unsatisfied with a number of things, including her and the

baby being moved to an unsecured floor (no security), no one took the baby to the nursery so that she could get some sleep, and the doctors were excessively pushy about breastfeeding, even though she knew it wasn't right for them (based on previous baby). "By the time I'm [was] getting ready to go home I was in tears, feeling like I am a horrible mom because everyone and their mother had asked me if I was going to breastfeed, so I tried and it was horrible experience again," she said.

For the other three participants with one previous pregnancy, their prior experiences varied greatly, but their labor and delivery care for the current pregnancy was perceived as outstanding, with A7 and A10 describing their care as a 10. Participant A5 designated her experience as a 9, but only because of her issues with the epidural, she says, "I would say ...that is the only thing debunking it from a 10."

Expectations varied as greatly as well between individuals. When asked about expectations going into labor and delivery, participant A5 stated "other than psychologically expecting him to come at like 35 weeks, and not showing up till due date, I really only had that expectation. I didn't really go in with an expectation cause I understand you don't really know how your birth is going to really flow," while participants A5 and A7 felt they already knew what to expect, since they had chosen their care providers and felt very comfortable with them.

> A7: I already had doctors that I liked ... so I just wanted to make sure that I could keep all of my same doctors, and nurses, and hospitals and everything. I think my doctor explained everything great.
>
> A10: I knew I wanted a midwife ... so I actually started the pregnancy with the mid-wife that delivered my first and then we moved to [this base]. Having mid-wife care from the start this time was so much better. I could go to my provider and as ask a question and trust the answer. I didn't feel like I had to fight for what I wanted.

For two of the participants (A7 & A10), previous experiences with OB care or the birthing process could be defined as frightening, unsatisfactory, or less than great when compared to their current care.

> A7: My first experience was crazy. And then this time I didn't really know what to expect because I had never just gone in and had a baby.
>
> A10: The OB was out in the hallway saying he was going to C-section if she didn't get this baby out, so I feel like I had to scrape by and get everything. I was on tenterhooks waiting on that one because I didn't know what I was going to have to fight, waiting till the last min to go to the hospital.

Theme 3: Experiences and Perceptions Influence Insurance Choices

According to TRICARE (2015a), prime insurance is the health care option that allows beneficiaries to receive most of their routine care through their primary care manager (PCM) who is selected, or assigned, at a military hospital or clinic, a civilian network provider, or a primary care physician in the US Family Health Plan, depending on the location of the patient and the service member; residence location and military hospital/clinic capacity levels determine whether a beneficiary has to report to a military hospital/clinic or a civilian PCM. At the local base, prime insurance recipients are referred to the pink or blue team at the base's local hospital, or may choose to seek out a covered midwife.

TRICARE *standard* is an option for beneficiaries that allows the patient to manage their own health care, as well as gives an individual the ability and "freedom to seek care from any TRICARE-authorized provider" (TRICARE, 2015b). TRICARE standard includes a monthly premium, annual deductible, and cost-shares. The primary distinction between the two plans is the ability to choose who you see, when you want to

see them, and the small cost associated with having that freedom. According to TRICARE (2015b), for the individual plan, the yearly deductible for Active Duty Family Members (ADFMs) is $50 for E-4 and below, and $150 for E-5 and above (including officers). For families, the yearly deductible is $100 for E-4 and below, and $300 for E-5 and above (including officers).

Out of the 12 participants, five chose to make the switch to standard. Participant A10 would have switched to standard, but was able to see a midwife without changing insurance programs, "I ended up getting what I wanted in general because I had her." When asked about choosing standard over prime, participants replied with the following:

> A7: My husband and I ... already had doctors and stuff that [we] liked and ... so I just wanted to make sure that I could keep all of my same doctors, and nurses, and hospitals and everything
>
> A9: I have had problems with pregnancies before. My first pregnancy was a stillborn... that was on base. That's one of the reasons I didn't go on base. It was a young guy, he wasn't bad or anything, I am not trying to talk bad about him, but I just don't think he had a lot of experience, so and that's why I decided to go off base with my second.
>
> A11: I wanted a more peaceful experience. I didn't, I wanted a provider that believed that birth was not an emergency, unless it was an emergency... if it is then let's do something, but until then, I trust you and I trust your body and know that this is a normal process.
>
> A13: I chose standard when I got pregnant, because I wasn't satisfied with the way the base hospital did their division of obstetrics with the pink and the blue team and also I knew I wanted a little more independence and freedom and deciding my birthing plan, so I knew I wanted natural, midwife, the option to eat and move around and not be hooked up to a machine, so I pretty much had to go standard to do that.

Only two participants with previous pregnancies decided to stay on prime. Participant A3 delivered her first child in the civilian sector. Her overall opinion of the MHS was fair and states that if she were to do it all over again, she would have asked more questions;

however, she states that they did not originally switch to standard because they did not believe it would have been worth the cost:

> It was just different. I guess because I didn't have that connection with the doctor. But I know if I would have switched to standard I would have had ... me and my husband talked about it and [we decided] why pay for something when you don't have to if you're getting the level of care you feel is adequate for you. As long as we don't have a problem, and everything goes smoothly, he was like why pay for it?

She also notes that "[Another reason] I chose to stay prime and go to [the close civilian hospital] is because I had a tubal ligation after mine and I knew that [the further hospital] wouldn't do it, since it is a Catholic hospital".

Participant A5 also had one previous delivery and decided to stay prime. It is unknown where her previous care was administered, but it was not conducted at the local base focused on in this study.

Theme 4: Recommendation and Hospital Rating Trends

During interviews participants overwhelming praised doctors, nurses, and staff they interacted with during the labor and delivery process, saying things like, "they exceeded my expectations" (A1), "I loved the hospital, it's great, doctors and nurses were good" (A10), "I had a great experience. They were very nice" (A4), and "The doctors were always really quick, the nurses were really friendly, and I absolutely loved that they had a 24hr food bar" (A5). Regardless of demographics, all participants described their experience as a *nine* or above, with the exception of A3.

Data Verification

Data verification, or validation, is an important step in the research process, which allows researchers to not only gain perspectives, but also the ability to translate ideas into

practice as strategies or techniques (Creswell, 2013). For this study clarifying and thick description were used. According to Creswell (2013), verification through clarifying outlines researcher biases to enable the reader to understand any assumptions or positions held by the researcher during the time of the study. These are presented in the form of researcher comments relating to experiences, perceptions, or prejudices that may have shaped the interpretation or approach of the study. Rich or thick description enables the reader to draw conclusions about transferability through the researcher's detailed portrayals of the participants or settings within the study. Using this method requires the researcher to provide numerous details when writing about a particular theme; it can be considered rich if the information is substantial and consistent (Creswell, 2013).

As part of the clarifying process, it is important to note that I am the spouse of an active duty service member and have utilized the TRICARE process for labor and delivery care. I also have a strong interest in the topic, personal experiences, and biases that could play a role in the interpretation of the information obtained. While I had an overall wonderful experience with my labor and delivery care while stationed [the local base], I am aware that many did not. I am confident in my ability to leave these particular feelings out of the research, due to the understanding that individual experiences can be affected variety of factors. However, this does mean that I may have stronger biases towards some of the common themes that affect maternity care than someone without such similar experiences.

The main bias was the factors that affect patient satisfaction. Many common themes emerged from the literature and made an impression on my views of women's experiences. It was believed these topics would also be found in the research, with the

most important being personal control over the birthing process*;* however, this particular theme was not found among the population studied. In addition, thick description can be seen throughout Chapter 4 through the use of direct quotes from transcribed interviews. Verbatim responses can be viewed in Appendix K.

Participant Outcomes

During the interview process participants were exceedingly helpful and open about their experiences. All appeared to be in their homes and most looked to be in a calm, stress free, environment. Only one participant seemed to be preoccupied with other activities at the time; this particular session was conducted after the individual had arrived home from work and she was simultaneously taking care of other responsibilities. Based on the interactions with the participants, it is believed that all were in a healthy state of mind and none relived any painful trauma. No emotional breakdowns occurred, and all individuals appeared to end the session jovial and willing to continue to help if more questions arose. Further communications were made with two individuals post-interview. One offered to relay messages to friends about the research project and another shared the birth story she had written.

Summary

The data in this chapter revealed three key concepts: (a) participants overwhelming had one or more complaints or complications with their maternity care; (b) for a majority of the participants, previous experiences on standard were negative, which influenced their choices in medical care, and (c) differences in satisfaction may be seen when a patient's personal experiences and beliefs about an occurrence are met or

excused. In Chapter 5 an interpretation of the data is provided, along with recommendations for future studies and implications for social change.

Chapter 5: Summary, Conclusion, and Recommendations

Maternity care has become a special interest within the military's medical community due to the lagging satisfaction ratings received year after year (TRICARE, 2013a). Quantitative research conducted through TRISS has revealed that while women who deliver within the MHS are highly satisfied with many aspects of care, they overwhelmingly would not recommend the hospital to family or friends, and their overall hospital ratings are significantly below benchmarks (TRICARE, 2013a). A lack of independent research on the MHS has also lead to a gap within the literature. Harriott et al. (2005) were the last researchers to investigate the potential factors that affected care by looking at the satisfaction levels of women within the MHS and phenomena associated with a woman's likelihood of recommending the medical treatment facility for LD. They found that most of the factors assessed were important in determining whether women would recommend the hospital where they delivered, with over half of the patients not satisfied with the care received (Harriott et al., 2005).

The purpose of this study was to understand women's experiences and expectations with LD care within the MHS, with the hopes of discovering any hidden factors of care that may be associated with positive or negative feelings towards OB-GYN services as well as overall care received during LD stays, which could lead to the development of a new theory regarding patient satisfaction. By interviewing mothers who have recently given birth as a dependent or active duty member, the purpose of this dissertation was to hear the voices of women through their answers to the following questions:

RQ1: What are women's lived experiences with labor and deliver hospital stays

in the Military Healthcare System?

RQ2: Prior to delivery, what were women's expectations with labor and deliver hospital stays in the Military Healthcare System?

RQ3: What are some of the inconsistencies seen between experiences and expectations?

As a subinquiry through this study I hoped to determine if any common themes would arise with satisfaction, expectations, and experiences, such as "Have experiences or expectations before being admitted for labor and delivery altered an individual's outlook as described by the Discrepancy Theory," (Sawyer et al., 2013).

Data collection was conducted during a 6-month timeframe. Participants were interviewed about their experiences with LD care and hospital stays. During transcription and coding several themes were discovered:

- It was revealed that women's issues with care mostly focuses on prenatal interactions;
- Expectations, experiences, and perceptions are multifaceted, and do not align well with the theory selected for this study (discrepancy theory);
- Differences between expectations and experiences appear to have minor effects on overall recommendations and hospital ratings;
- Women who choose standard care are mostly influenced by negative factors, whether they are from past experiences, perceptions of care, or limitations on options; and
- Similar to TRICARE's most recent survey study (2013a), ratings and recommendations for purchased care are higher than direct care.

Unlike a vast majority of the literature reviewed in this study, pain management did not appear to have a direct effect on low satisfaction. It is unknown if this is due to a lack of effect on satisfaction overall or if participants were generally happy with this particular aspect of care.

Interpretation of Findings

Research Question 1 of this study was focused on understanding women's experiences with labor and delivery hospital stays within the MHS. Through analysis, an unexpected theme emerged from the data: women interviewed primarily had negative experiences with prelabor or maternity care (Theme 1). Many women stated that the problems they encountered were less with the hospital itself, and more with the [local base] team. This was an unexpected finding because women were being specifically asked to talk about their LD care. As this became a more prevalent occurrence, the interviews were adapted to include a question about maternity care. This finding may suggest a need for a more holistic approach to studying women's experiences with the entire pregnancy, rather than focusing solely on one aspect or the other. Currently, TRICARE (2013a) focused their survey on LD care and the hospital stay only. A deeper look into prenatal visits may help researchers understand patient's perceptions before labor and delivery.

In the literature review, I noted that within the general healthcare community several key factors have been shown to affect patient satisfaction in qualitative analysis. These factors included physical and emotional support, access to staff, communication, efficiency, and effective organization (Sofaer & Firminger, 2005). More specifically, in LD care, increased support for breastfeeding, longer stays in the delivery suite, and

education regarding infant care were associated with higher rates of satisfaction with the overall process. The participants in this study consistently addressed neither set of factors, although communication during routine maternity care visits was mentioned on a few occasions (Theme 1).

Research Question 2 was designed to understand women's expectations prior to delivery, with the assumption that satisfaction would be affected by the difference between the expected outcomes and her experiences. The discrepancy theory model was first used in healthcare by Linder-Pelz (as sited by Mahomad et al., 2010) who noted that patients had a significantly higher satisfaction rate when their expectations and experiences were both positive. Conversely, patients who had less than favorable expectations and experiences were less satisfied. Those who had favorable expectations, but negative experiences varied, and have thus lead other researchers to concluded that expectations alone do not determine satisfaction, but rather, it is a combination of experiences and expectations. Theme 2 of this study supports this latter school of thought: Expectations, experiences, and perceptions are multifaceted. In addition, data from this study did not align well the discrepancy theory, other than when participants had favorable expectations, but negative experiences, their satisfaction varied. While expectations do in fact play a role on the outcome of satisfaction, they are not a major driver of it in all situations. Mahomad et al. (2010) note that differences in satisfaction can be seen when a patient's personal experiences and beliefs about an occurrence are met or excused. For example, if a patient expected to be seen by a doctor within a certain amount of time, but was kept waiting for a significantly longer period, she may still note the experience as satisfactory if the doctor's tardiness was met with an acceptable excuse.

This particular instance was seen several times throughout the study. Some of the women that faced complications during labor and delivery, or with maternity care, still described their overall experiences as great, even excusing the behaviors of doctors and nurses when they did not agree with a procedure, or they had a negative experience. Mahomad et al. (2010) did not create a novel theory, but the research conducted in this study supports their ideology. More investigation into this with more participants could further support a new theory of satisfaction; however, there is not enough data in this study to make support of the theory unequivocal.

Theme 2 also addresses Research Question 3: "What are some of the inconsistencies seen between experiences and expectations?" The data show that expectations, experiences, and perceptions are multifaceted, and there is no clear pattern between the three. Regardless of high, medium, or low expectations, or complications, participants' overall views of the labor and delivery process were generally favorable. The aspects of care that were inconsistent with participant's expectations and experiences were also highly varied between each individual. Only three of the participants had birth plans (Table 1), and each noted something different that did not go according to their plan. Participants without birth plans also had some expectations, and almost all mentioned one aspect of the labor and delivery process that did not go how they envisioned it, yet they all generally described their experience as great.

Although combined expectations and experiences showed no sign of a general pattern, experiences did play a role on the participant's current choices for maternity care, labor and delivery options, and insurance plan (Theme 3). Participants using standard care overwhelmingly stated they chose to switch due to an incident that had occurred or

because their perception of the prime care option was not favorable. Only one participant chose standard care because of a "neutral" reason, which was to keep her nonmilitary care providers that she had acquired before getting married. Of the prime beneficiaries, two contemplated making the switch, but one stayed because she was able to get a midwife without moving over, and the other would not have been able to get a tubal ligation had she chosen standard. While these individuals did not make the switch, they did contemplate the idea based on perceptions and previous experiences. Interestingly, most women who considered switching to standard, or who did, generally had previous pregnancies.

Another common theme, Theme 4, was the recommendations and hospital ratings. Regardless of demographics, expectations, or experiences, all participants described their perception of care as a 9 or above, with the acceptation of A3. A3 could be considered an outlier because she was one of the only participants who chose to stay prime with her second child and was subjected to uncommon practices due to overcrowding during her stay, such as being moved to an unsecured floor and having to keep her child with her at all times because there was no nursery on the unsecured floor.

When viewing the data in this study and TRICARE's (2013a) survey outcomes, a similar trend became evident. Participants who chose to switch to standard, or purchased care (PC), were generally happier with their experiences and described their labor and delivery as outstanding. TRICARE (2012) data shows that ratings for PC are above national benchmarks. Conversely, participants who chose to stay on prime, or direct care (DC), rated their overall view of the hospital below national averages on the TRICARE survey (2013a). In this study, participants varied, but were generally highly satisfied.

Limitations

This study was conducted with TRICARE beneficiaries stationed a single military base located in the Midwest. Although this duty location is open to all branches of the military, 11 out of the 12 participants are affiliated with the Air Force; this limiting factor may have played a role on the outcomes of the study. TRICARE's (2013a) yearly inpatient survey also points to higher overall hospital ratings and likelihood of recommending the hospital for Air Force beneficiaries. This rating is above national benchmarks (TRICARE, 2013a).

In addition to limiting branch inclusion, the sample was only gathered from one base. To allow for a wider range of views, expectations, and overall views this study could be conducted across multiple regions and bases, as well as a much larger sample to ensure inclusion of a range of LD types.

Participants with any type of complications were excluded from this study. That included mostly women who needed additional prenatal care, monitoring, or bed rest. This was done in an attempt to limit non-routine procedures during the labor and delivery process. This limiting factor may or may not have been a good choice overall, but in the future it should be reinvestigated to see if the use of additional services has a significant affect on overall satisfaction when compared to those that had no additional services for that particular procedure.

During the qualification period I had to heavily rely on participants' self-reporting for uncomplicated pregnancy and memory recall. While research has shown that recall for a significant event, like birth, is valid up to 12 months, this is a limiting factor. Some women suddenly remembered key events when triggered my probing questions; others

said there really was nothing memorable about their labor and delivery process. While this may be true, small key interactions could have been lost in the simplicity of the testimony of their experiences. One participant kept a journal throughout her whole experience, and as she read through it, she found instances that she had already forgotten, but was suddenly remembering because she wrote it down.

Implications for Social Change

This goal of this dissertation was to understand the lived experiences and expectations of women who have given birth within the MHS and to develop a novel theory grounded in the data. Although there is not enough supporting data to create a novel theory, this investigation does support Mahomed et al.'s (2010) ideology that differences in satisfaction can be seen when a patient's personal experiences and beliefs about an occurrence are met or excused. In order to create positive social change, researchers in the military medical field must take a more hands-on approach to understanding the dynamic system of maternity care and LD. By taking the findings from this study, and that of Mahomed et al. (2010), there is a potential to create a novel theory of satisfaction for maternity care.

In addition to supporting Mahomed et al.'s (2010) ideology, this study points to the notion that the MHS is not meeting laudable standards as a whole. The DoD states they are focused on ensuring the highest standards of care (as cited by Jacobson & Jensen, 2011), yet the results found here, and in the yearly TRISS (TRICARE 2012, 2013a), express a different view. It is outstandingly clear that satisfaction is multifaceted, and that in pregnancy, as well as labor and delivery, this process as a whole is exceedingly dynamic; but the research shows a gap between the DoD's goals and the

outcomes based on patients' own accounts. In general, the MHS is missing the opportunity to understand women's needs with maternity care and labor and delivery (LD) because they are treated as two separate events. If one were to include TRICARE's Outpatient Satisfaction Survey (Department of Defense [DoD], 2014) they would begin to see a pattern. The TROSS (DoD, 2014) summary results show that patients are highly unsatisfied with direct care received through the base when compared to national benchmarks and purchased care. The trends in this study echo the combined results of the TROSS (DoD, 2014) and the TRISS (2013a), which is that patients are generally satisfied with the labor and delivery process, but they had the most complaints about staff throughout prenatal care, or outpatient care. This points to a disturbing trend that can affect how we define satisfaction and successful patient centered care. It is proposed that TRICARE join prenatal care and the labor and delivery process together to create a separate Maternity Care Satisfaction Survey, in which the focus is not divided, but combined, to give doctors, policy makers, and the healthcare community a better view of maternity care as a whole and women's health.

It is believed that a lot of the women who participated in this study will think about their labor and delivery process differently in the future. This investigation gave them the opportunity to reflect upon their experiences, expectations, and their wants/needs, which some had never thought about before or even after their baby was delivered. In the future, these women may be more adamant about their wants for labor and delivery and be more vocal about their likes and dislikes. As Health Psychologists, I believe it is our part of our duties to inform patients of their rights as a patient. This area of healthcare is no different than any other. Women should be able to make informed

choices and be able to be knowledgeable about their options. In the future it would be ideal to see more Health Psychologists in roles that support the patient centered model and educating patients.

Although I was not able to create a new theory, positive social change can still be implemented through the results of this study and the suggestions made for the MHS. One of the key conclusions that were made was the number of complaints and complications that women were having during the LD process and during prenatal care. The fact that the majority of the women in this study had one or more complications, or complaints, during the LD process and maternity care shows us that more can be done to improve this area. Research shows us that a woman's short stay at the hospital has the potential to impact the wellbeing of both her and her baby; therefore, we must do more to ensure mother and baby are well taken care of and are not getting just "ok" service.

Recommendations for Action

Research suggests healthcare is moving towards more patient-lead care, but that pregnancy is unique because women have many options to choose from throughout the entire pregnancy and in labor and delivery. This is due to the nature of care being delivered. Women giving birth have many choices that are optional and unique to each of them. There are generally no other medical procedures or care options where patient choices are potentially available as is found in maternity care. In most cases, medical procedures and their course of action are directed solely by the provider. LD care is one of the only services where the patient can choose from a variety of options including medical interventions and how those are delivered at almost any given time during the process. It has been shown that patient satisfaction is a multifaceted concept and that

pregnancy is even more complex. However, the findings in this study revealed three key concepts regarding women's LD and prenatal care satisfaction: (a) participants overwhelming had one or more complications with their maternity care, (b) previous experiences for a majority of the participants on standard were negative, which influenced their medical care choices, and (c) differences in satisfaction may be seen when a patient's personal experiences and beliefs about an occurrence are met or excused.

These important findings should be a call to action for researchers in the military space. There are key elements within this study that could help improve how women are receiving their care and how doctors and nurses can better influence experiences.

Recommendations for Further Study

The purpose of this study was to understand women's lived experiences with labor and delivery, in hopes to discover a novel theory that was grounded in the research. Although there was not enough supporting data to create a new theory, several important findings were revealed. These themes are important and could have significant impacts on how military healthcare approaches care in the future. Although more supporting data are needed to form new policies, this study could help guide the direction for additional research. Initial investigations should expand this study to a wider sample size that was more inclusive of all branches and bases. If there were a similar pattern, researchers could expect to see women unhappy, at least in some small aspect, with their maternity care before labor and delivery.

Further investigation into what causes prime members to switch to standard is also recommended for future research. The Congressional Budget Office (2014) notes

that between 2010 and 2012 the cost of providing healthcare to eligible beneficiaries increased by 130%. In addition, purchased care costs in 2012 were $15.4 billion, which was the largest share of the Department of Defense's (DoD) health care funding (Congressional Budget Office, 2014). Supplementary research could provide insight into reasons why prime members switch, and how to reduce the changes, which may save the DoD money.

Lastly, differences in satisfaction when patients' personal experiences and beliefs about an occurrence are met or excused should be investigated further. Mahomed et al. (2010) first described the phenomena, yet did not create a novel theory. There is enough support in this study to suggest a pattern, but not enough to form a theory grounded in the research.

Researcher's Thoughts

Overall, I believe this was an important study in furthering the understanding of many topics, including patient satisfaction, expectations and experiences with labor and delivery, maternity care within the MHS, and base delivered prenatal care. While data collected for this investigation was limited to a relatively small sample size from one base, I believe the results align well with TRICARE's yearly evaluation the TRISS and the TROSS. This concurrence implies that, although the sample was not as diverse as I had hoped, that there are still similar trends to the larger population. In addition, a deeper investigation into this area could change how professionals practice medicine as a society, particularly within the military community and in maternity care. If the medical community were to stop treating prenatal care and LD as two separate occurrences, and

instead view it as one long *treatment*, they may be able to improve satisfaction, experiences, and overall health and wellbeing.

Looking back, there is nothing I would have changed about this study. Given the parameters of time and money, I believe this study contributed an understanding of care that may not have been apparent before, as well as supported ideologies that have not been turned into theories yet. The path from here is strong, and there is a clear vision for where to take future research; it should be repeated with a larger and more dynamic sample across the entire military community. Only minor changes were made along the way, such as wording, which helped clarify a few of the qualifying questions. In additional, the use of a hermeneutical approach, which allows the researcher to adapt questioning from interview to interview, helped shape the questions and sharpen me to be able quickly and rapidly identify the information that was important and encourage the participant to expand on significant details.

Overall, the current theories available in medicine and patient satisfaction are far from congruent with the multifaceted area of maternity care and LD, but I believe this study will have a great impact on the community and the future of theories in this field.

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Appendix A

Overall Summary: TRISS Satisfaction Ratings

					Product Line[2]		
	CMS Benchmark	DC & PC Combined[1]	Direct Care[1]	Purchased Care[1]	Medical[1]	Surgical[1]	OB[1]
Overall Indicators							
Overall Hospital Rating	68%	65% -	65% -	66% -	68%	72% +	54% -
Recommend Hospital	70%	69% -	68% -	70%	72% +	76% +	61% -
Composites							
Communication with Doctors	81%	83% +	84% +	81%	80% -	88% +	83% +
Communication with Nurses	77%	81% +	82% +	78% +	80% +	82% +	78% +
Communication about Medicines	62%	70% +	72% +	66% +	70% +	75% +	75% +
Responsiveness of Hospital Staff	65%	70% +	74% +	64% -	67% +	71% +	74% +
Discharge Information	83%	87% +	88% +	86% +	84% +	91% +	89% +
Pain Management	70%	71%	71%	70%	68% -	77% +	73% +
Individual Items							
Cleanliness of Hospital Environment	72%	74% +	74% +	73%	75% +	78% +	72%
Quietness of Hospital Environment	59%	62% +	64% +	57% -	61% +	65% +	72% +

[1]"+" indicates significantly above the benchmark. "-" indicates significantly below the benchmark.
[2]Ratings below the hospital level are weighted rather than patient-mix adjusted: Product Lines, Beneficiary Categories.

Figure 1A. Individualized composites and overall ratings of obstetrical care with indicators of above or below national averages. TRICARE (2012). *2012 TRICARE inpatient satisfaction survey (TRISS): Report of findings* (Defense Health Cost Assessment and Program Evaluation [DHCAPE] Publication).

Appendix B

Purchased Care Results: Composites and Individual Items

	Overall Hospital Rating[1]	Recommend Hospital[1]	Communication with Doctors[1]	Communication with Nurses[1]	Communicate About Medicines[1]
Benchmark	68%	70%	81%	77%	62%
PC Overall	66% -	70%	81%	78% +	66% +
TRO North	63% -	67% -	80%	77%	66% +
TRO South	66% -	71%	81%	78% +	66% +
TRO West	68%	72% +	80%	78%	67% +
Medical[2]	65% -	69%	75% -	76%	63%
Surgical[2]	72% +	76% +	85% +	79% +	69% +
OB-GYN[2]	62% -	72% +	84% +	79% +	73% +

[1]"+" indicates significantly above the benchmark. "-" indicates significantly below the benchmark.

	Overall Hospital Rating[1]	Responsiveness of Hospital Staff[1]	Discharge Information[1]	Pain Management[1]	Cleanliness of Hospital Environment[1]	Quietness of Hospital Environment[1]
Benchmark	68%	65%	83%	70%	72%	59%
PC Overall	66% -	64% -	86% +	70%	73%	57% -
TRO North	63% -	64%	86% +	70%	71%	53% -
TRO South	66% -	64%	86% +	70%	73%	59%
TRO West	68%	63% -	87% +	71%	74% +	55% -
Medical[2]	65% -	58% -	81% -	67% -	71%	53% -
Surgical[2]	72% +	66%	89% +	76% +	77% +	61% +
OB-GYN[2]	62% -	72% +	90% +	76% +	75% +	71% +

[1]"+" indicates significantly above the benchmark. "-" indicates significantly below the benchmark.

Figure 1B. Individualized composites and overall ratings of purchased obstetrical care with indicators of above or below national averages. TRICARE (2012). *2012 TRICARE inpatient satisfaction survey (TRISS): Report of findings* (Defense Health Cost Assessment and Program Evaluation [DHCAPE] Publication).

Appendix C

Direct Care Results: Composites and Individual Items

	Overall Hospital Rating[1]		Recommend Hospital[1]		Communication with Doctors[1]		Communication with Nurses[1]		Communicate About Medicines[1]	
Benchmark	68%		70%		81%		77%		62%	
DC Overall	65%	-	68%	-	84%	+	82%	+	72%	+
Army	63%	-	65%	-	84%	+	81%	+	72%	+
Navy	63%	-	68%	-	84%	+	81%	+	70%	+
Air Force	72%	+	75%	+	86%	+	85%	+	74%	+
Medical[2]	69%	+	74%	+	83%	+	83%	+	74%	+
Surgical[2]	72%	+	76%	+	89%	+	83%	+	77%	+
OB-GYN[2]	52%	-	57%	-	83%	+	78%	+	76%	+

	Overall Hospital Rating[1]		Responsiveness of Hospital Staff[1]		Discharge Information[1]		Pain Management[1]		Cleanliness of Hospital Environment[1]		Quietness of Hospital Environment[1]	
Benchmark	68%		65%		83%		70%		72%		59%	
DC Overall	65%	-	74%	+	88%	+	71%		74%	+	64%	+
Army	63%	-	72%	+	87%	+	70%		76%	+	64%	+
Navy	63%	-	73%	+	89%	+	69%		70%	-	62%	+
Air Force	72%	+	78%	+	89%	+	73%	+	75%	+	66%	+
Medical[2]	69%	+	73%	+	86%	+	69%		78%	+	66%	+
Surgical[2]	72%	+	74%	+	92%	+	77%	+	79%	+	68%	+
OB-GYN[2]	52%	-	74%	+	89%	+	72%	+	71%	-	73%	+

[1]"+" indicates significantly above the benchmark. "-" indicates significantly below the benchmark.

Figure 1C. Individualized composites and overall ratings of direct obstetrical care with indicators of above or below national averages. TRICARE (2012). *2012 TRICARE inpatient satisfaction survey (TRISS): Report of findings* (Defense Health Cost Assessment and Program Evaluation [DHCAPE] Publication).

Appendix D

TRICARE Inpatient Satisfaction Survey Results 2008 for Purchased and Direct

	DC Overall 2008[1]	2008 Civilian HCAHPS Benchmark	DC Medical	DC Surgical	DC Obstetric	Army[1]	Navy[1]	Air Force[1]		DC Overall 2007
Overall Satisfaction										
Overall Hospital Rating	**53.3**	64.9	61.0	61.9	41.1	**51.2**	**54.0**	**58.8**		51%
Recommend Hospital	**56.8**	69.9	64.0	66.2	44.6	**54.4**	**59.9**	**59.1**		54%
HCAHPS Composites										
Nurse Communication	**68.9**	74.1	73.3	75.2	60.8	**67.9**	**68.8**	72.1		66%
Doctor Communication	**76.3**	79.0	75.7	84.0	71.9	**75.7**	**75.9**	78.5		73%
Communication about Medications	**67.3**	58.1	66.7	71.1	65.4	**66.7**	**69.2**	**65.8**		65%
Responsiveness of Hospital Staff	62.2	61.7	62.6	65.6	59.5	60.0	**64.5**	64.4		59%
Pain Management	**61.6**	69.0	60.1	69.7	57.6	**60.5**	**62.0**	**64.2**		60%
Discharge Information	**83.9**	80.9	80.4	88.9	84.0	**83.8**	**83.8**	**84.5**		83%
DoD Composites[2]										
Your Family and Friends	81.5	N/A	85.1	87.4	75.3	81.0	80.5	84.6		79%
Interaction with Other Hospital Staff	70.5	N/A	71.0	75.3	66.0	71.9	68.3	70.3		67%
Patient Safety	65.9	N/A	69.7	70.9	59.3	66.9	64.3	65.6		63%

*[1]Numbers in **bold** text are significantly different from the 2008 civilian HCAHPS benchmark. Statistical tests to examine differences between Product Line (Medical, Surgical, and Obstetrics) and the 2008 HCAHPS civilian benchmark were not performed.*

[2]N/A (not available)—for the DoD composites, civilian benchmark data are not available for comparison because these questions are not included in the HCAHPS survey.

CareFigure 1D. Individualized composites and overall ratings of direct obstetrical care with indicators of above or below national averages. TRICARE (2008). *TRICARE inpatient satisfaction survey: Overall survey results of hospital inpatients: July-September 2008* (Office of the Assistant Secretary of Defense Publication, Contract No. W81XWH-06-P-1057).

Appendix D

TRICARE Inpatient Satisfaction Survey Results 2008 for Purchased and Direct Care

	PC Overall 2008[1]	2008 Civilian HCAHPS Benchmark	PC Medical	PC Surgical	PC Obstetric		North[1]	South[1]	West[1]		PC Overall 2007
Overall Satisfaction											
Overall Hospital Rating	**60.9**	64.9	58.5	66.9	56.5		**58.2**	63.0	**61.3**		60%
Recommend Hospital	**64.8**	69.9	59.9	70.4	66.1		**63.3**	**65.2**	**65.6**		64%
HCAHPS Composites											
Nurse Communication	**69.1**	74.1	65.6	72.6	71.0		**68.7**	**70.3**	**68.2**		68%
Doctor Communication	**75.0**	79.0	68.7	80.6	79.4		**74.8**	**75.1**	**75.2**		75%
Communication about Medications	**61.6**	58.1	55.2	65.1	68.8		**63.3**	59.8	**61.2**		61%
Responsiveness of Hospital Staff	**56.5**	61.7	48.1	57.7	68.5		**55.4**	**56.3**	**57.4**		57%
Pain Management	**66.0**	69.0	59.4	70.1	68.7		**64.1**	67.1	67.0		65%
Discharge Information	**82.1**	80.9	75.5	88.8	84.7		80.8	81.7	**83.7**		82%
DoD Composites[2]											
Your Family and Friends	83.5	N/A	80.6	87.0	83.8		83.3	84.6	82.4		83%
Interaction with Other Hospital Staff	76.7	N/A	73.5	80.0	79.8		77.8	76.9	75.3		75%
Patient Safety	70.6	N/A	68.0	73.5	71.6		70.0	71.8	70.0		68%

*[1]Numbers in **bold text** are significantly different from the 2008 civilian HCAHPS benchmark. Statistical tests to examine differences between Product Line (Medical, Surgical, and Obstetrics) and the 2008 civilian HCAHPS benchmark were not performed.*

[2]N/A (not available)—for the DoD composites, civilian benchmark data are not available for comparison because these questions are not included in the HCAHPS survey.

Figure 2D. Individualized composites and overall ratings of direct obstetrical care with indicators of above or below national averages. TRICARE (2008). *TRICARE inpatient satisfaction survey: Overall survey results of hospital inpatients: July-September 2008* (Office of the Assistant Secretary of Defense Publication, Contract No. W81XWH-06-P-1057).

Appendix E

TRICARE Inpatient Satisfaction Survey Results 2009 for Purchased and Direct Care

	MHS Overall 2009	Direct Care Overall 2009	Civilian HCAHPS Benchmark	DC Medical	DC Surgical	DC Obstetric	Army	Navy	Air Force		Direct Care Overall 2008
Overall Satisfaction											
Overall Hospital Rating	**55.9**	**53.0**	63.5	61.1	58.3	42.1	**51.3**	**52.4**	**59.2**		53.3
Recommend Hospital	**60.6**	**57.7**	68.4	66.7	64.5	45.1	**55.0**	**58.9**	**63.7**		56.8
HCAHPS Composites											
Nurse Communication	**70.0**	**69.9**	74.2	75.2	71.9	63.8	**69.6**	**69.0**	72.5		68.9
Doctor Communication	**75.7**	**75.9**	79.0	76.0	81.1	72.6	**74.9**	**76.3**	78.0		76.3
Communication about Medications	65.7	**67.2**	58.1	65.7	68.3	67.8	**66.1**	**68.9**	**67.2**		67.3
Responsiveness of Hospital Staff	61.1	62.2	61.8	63.1	61.3	61.8	**59.7**	63.7	**66.9**		62.2
Pain Control	63.3	**61.7**	69.0	60.4	64.8	60.6	**60.2**	**62.3**	**65.1**		61.6
Discharge Information	**84.5**	**85.0**	80.9	81.9	88.6	85.5	**83.7**	**86.1**	**86.7**		83.9
DoD Composites[2]											
Your Family and Friends	82.3	81.4	N/A	85.1	83.8	77.2	80.4	81.5	84.3		81.5
Interaction with Other Hospital Staff	73.9	71.5	N/A	71.8	74.2	69.0	71.8	70.5	72.2		70.5
Patient Safety	69.1	67.3	N/A	70.6	70.1	62.5	67.2	67.6	67.2		65.9

[1]*Numbers in **bold** text are significantly different from the civilian HCAHPS benchmark. Statistical tests to examine differences between Product Line (Medical, Surgical, and Obstetrics) and the HCAHPS civilian benchmark were not performed.*

[2]*N/A (not available)—for the DoD composites, civilian benchmark data are not available for comparison because these questions are not included in the HCAHPS survey.*

Figure 1E. Individualized composites and overall ratings of direct obstetrical care with indicators of above or below national averages. TRICARE (2009). *TRICARE inpatient satisfaction survey: Overall survey results of hospital inpatients: July-September 2009* (Office of the Assistant Secretary of Defense Publication, Contract No. W81XWH-06-P-1057).

Appendix E

TRICARE Inpatient Satisfaction Survey Results 2009 for Purchased and Direct Care

	PC Overall 2009[1]	Civilian HCAHPS Benchmark	PC Medical	PC Surgical	PC Obstetric		North[1]	South[1]	West[1]		PC Overall 2008
Overall Satisfaction											
Overall Hospital Rating	**62%**	64%	57%	68%	61%		**61%**	63%	62		61%
Recommend Hospital	**66%**	68%	62%	72%	67%		**66%**	**66%**	67%		65%
HCAHPS Composites											
Nurse Communication	**70%**	74%	67%	73%	73%		**71%**	**72%**	**68%**		69%
Doctor Communication	**75%**	79%	69%	82%	77%		**75%**	77%	**74%**		75%
Communication about Medications	**63%**	58%	56%	66%	69%		**62%**	**61%**	**64%**		62%
Responsiveness of Hospital Staff	**59%**	62%	51%	61%	69%		60%	**57%**	60%		56%
Pain Control	**67%**	69%	57%	72%	71%		**65%**	68%	67%		66%
Discharge Information	**84%**	81%	78%	88%	86%		**84%**	**84%**	**84%**		82%
DoD Composites[2]											
Your Family and Friends	84%	N/A	83%	87%	83%		84%	85%	83%		83%
Interaction with Other Hospital Staff	78%	N/A	76%	82%	78%		80%	78%	76%		77%
Patient Safety	73%	N/A	71%	75%	72%		74%	72%	71%		71%

[1]*Numbers in **bold text** are significantly different from the Civilian HCAHPS benchmark. Statistical tests to examine differences between Product Line (Medical, Surgical, and Obstetrics) and the civilian HCAHPS benchmark were not performed.*

[2]*N/A (not available)—for the DoD composites, civilian benchmark data are not available for comparison because these questions are not included in the HCAHPS survey.*

Figure 2E. Individualized composites and overall ratings of direct obstetrical care with indicators of above or below national averages. TRICARE (2009). *TRICARE inpatient satisfaction survey: Overall survey results of hospital inpatients: July-September 2009* (Office of the Assistant Secretary of Defense Publication, Contract No. W81XWH-06-P-1057).

Appendix F

Overall Summary: TRISS Satisfaction Rating

					Product Line[2]			Beneficiary Category[2]			
	CMS Benchmark	DC & PC Combined[1]	Direct Care[1]	Purchased Care[1]	Medical[1]	Surgical[1]	OB[1]	AD[1]	AD Family[1]	Retirees & Family under 65[1]	Retirees & Family 65+[1]
Overall Indicators											
Overall Hospital Rating	68%	65% -	65% -	66% -	68%	72% +	54% -	55% -	55% -	72% +	78% +
Recommend Hospital	70%	69% -	68% -	70%	72% +	76% +	61% -	62% -	61% -	77% +	79% +
Composites											
Communication with Doctors	81%	83% +	84% +	81%	80% -	88% +	83% +	83% +	82% +	85% +	82% +
Communication with Nurses	77%	81% +	82% +	78% +	80% +	82% +	78% +	82% +	77%	83% +	80% +
Communication about Medicines	62%	70% +	72% +	66% +	70% +	75% +	75% +	80% +	72% +	73% +	67% +
Responsiveness of Hospital Staff	65%	70% +	74% +	64% -	67% +	71% +	74% +	74% +	71% +	71% +	67% +
Discharge Information	83%	87% +	88% +	86% +	84% +	91% +	89% +	90% +	89% +	88% +	84% +
Pain Management	70%	71%	71%	70%	68% -	77% +	73% +	72% +	71% +	74% +	74% +
Individual Items											
Cleanliness of Hospital Environment	72%	74% +	74% +	73%	75% +	78% +	72%	80% +	71% -	76% +	75% +
Quietness of Hospital Environment	59%	62% +	64% +	57% -	61% +	65% +	72% +	75% +	70% +	64% +	57% -

[1]"+" indicates significantly above the benchmark. "-" indicates significantly below the benchmark.
[2]Ratings below the hospital level are weighted rather than patient-mix adjusted: Product Lines, Beneficiary Categories.

Figure 1F. Individualized composites and overall ratings of in-patient care with indicators of above or below national averages. TRICARE (2012). *2012 TRICARE inpatient satisfaction survey (TRISS): Report of findings* (Defense Health Cost Assessment and Program Evaluation [DHCAPE] Publication).

Appendix G

Open-Ended Questions

1. Tell me about your birth experience
2. Looking back to before you delivered, what were your expectations regarding what your birth experience would be like? Was your experience similar to, or different from, how you expected it?

Appendix H

Consent Form

You are invited to take part in a research study of women's experiences and expectations with in-patient maternity care within the Military Healthcare System (MHS). The researcher is inviting individuals to be in the study who meet the following criteria: females who are active duty or dependents of an active duty member, aged 18-40, on TRICRE standard/prime, delivered a full term baby (37 weeks 0 days through to 41 weeks 6 days) while stationed at Offutt, AFB, and had an uncomplicated pregnancy with no outside medical factors affecting a need for additional specialized care. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Michelle Osborne (formerly Recame), who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to understand women's experiences and expectations of in-patient maternity care during the labor and delivery process within the Military Healthcare System.

Procedures:

If you agree to be in this study, you will be asked to:

- Engage with the researcher, Michelle Osborne, in an interview/conversation about your labor and deliver experience, which will take roughly 60-90 minutes and be audio recorded.
- Topic covered may include, but are not limited to you pregnancy, labor and delivery, experiences, expectations, your in-patient stay, and post delivery.

Here are some sample questions:

1. Tell me about your birth experience
2. Did you go the way you envisioned?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one associated with Walden University will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as reliving any upsetting or emotional moments during your pregnancy, your labor and delivery stay, or post delivery time. Being in this study would not pose risk to your safety or wellbeing.

The overall benefit of this study is to provide the medical and Military Healthcare community with a better understanding of patients' experiences and expectations during in-patient labor and delivery stays.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by encoding the data with reference numbers on a private hard drive that will be locked and secured in the home office of Michelle Osborne. Audio recordings, which will be digital, will also be stored on the hard drive. All data will be kept for a period of at least 5 years, as required by the university. After this period, all data will be permanently erased from the hard drive.

Contacts and Questions:

You may ask any questions you have now, or if you have questions later, you may contact the researcher via phone or email. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is **09-09-15-0289136** and it expires on **September 8, 2016**

Please print or save this consent form for your records.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By replying to this email with the words, “I consent”, I understand that I am agreeing to the terms described above.

Appendix I

Researcher Notes

9-25-15

Note: After day one (three interviews); Overall thoughts/ideas

Satisfaction seems to be, at the moment, linked to expectations

- Less expectation, higher satisfaction
- When expected needs not met, lower satisfaction
- Low expectations, needs met, but some complications, still overall highly satisfied

Examples:

- A4: no expectations, rated a 10
- A5: no expectations, but one complication, rated 9
- A3: some expectations not met, rated 8

All expectations (A4, A5, A3) were based on previous experiences

Two of the participants would recommend the hospital

One would recommend the hospital but with a warning to others

Overall, participants are happy (8-10) with the delivery, but not happy with prenatal care.

**Could this be what people are talking about on the TRICARE Survey?

01-20-16

Some of the things I expected to see have held true, but I have found it very interesting that despite negative things that happened during labor and delivery, that some still rate their overall experiences as “very well” or “great”. It is interesting to see that

even in the face of negative outcomes they are still overall satisfied with their care. I think this plays very well into the literature that has found patients' views of care are very complicated and that 1-2 instances of bad care did not change their overall outlook. Those that had little to no expectations were just as satisfied as those who had higher expectations (and those with birth plans). Most who were on their second or third birth had negative experiences in the past that helped shape the choices they made for their current birthing plans, which helped give higher ratings for the experiences we were talking about in our interviews.

Almost everyone rated their experience 9-10, but the reason behind those lies in the previous experiences with the hospital or other births.

02-18-16

Previous births: Ratings

- 0: 9.5, 10, 9, 9, 9
- 1: 8, 9, 10, 10
- 2: 10, 10, 10

Thoughts: with zero previous births, nothing to compare it to, but with a previous birth, if it did not meet expectations, then was rated lower; with precious birth, if it went better, then the rating was higher. Those with two or more births knew exactly what to expect and were prepared; meaning everything went according to the way they expected and prepared for.

- Maybe a theme and support for a "comparative theory of satisfaction"?

Detailed investigation:

Zero previous births

A1: Rated a 9.5 (would have rated 10, but doesn't like absolutes). **Expectations high**, had an extensive birth plan, not everything went according to plan, but says the doctors and nurses went above and beyond anything she could have prepared for. Complications: none

A4: Rated a 10. **Expectations low**. Says she was very open to the whole process, took birthing class, not stressed at all, knows she can't control it because she has seen it with her nieces and nephew's [births]. Complications: doctor burst her placenta inside her.

A8: Rated a 9 (would have given a 10 but didn't like that she got sent home and then her water broke 3 hours later). **Expectations low**. Only thing participant noted she expected that she could get an epidural and not to have a C-section. Complications: due to going into labor so quickly, she didn't get to have the epidural. Complications getting the placenta out.

A13: Rated a 9 (would have rated a 10, but she expected to give birth at the midwife center and didn't get to). **Expectations medium.** Had a general birth plan, no medications or interventions, and the ability to move around freely, as well as have control over the environment. Says her expectations were met. Complications: none

A14: Rated a 9 (would have rated a 10 but says she's not really sure if it was a 10 because she has nothing else to compare it to). **Expectations low.** Says she really didn't know what to expect because this was her first [seemed open and very understanding]. Complications: Baby's heart rate was dropping consistently due to labor stress, so she had an unplanned C-section.

Notes:

No matter if expectations were high, medium, or low, and in light of complications or not, all participants who had had zero previous births rated their experience as a 9 or above. Interestingly, ALL who gave below a 10 said they would have rated it a 10, except for either one minor issue, or because they didn't know if they should rate it a 10 without prior experience, or because they don't believe in absolutes.

Previous births: Ratings

- 1: 8, 9, 10, 10

One previous birth

A3: Rated an 8. **Expectations low**. Per the participant, she had no expectations going into this delivery; however, she was unsatisfied with a number of things: after delivery, her and the baby got moved to an unsecured floor (no security), no one took the baby to the nursery so that she could get some sleep, doctors were excessively pushy about breastfeeding, even though she knew it wasn't right for them (based on previous baby). All unsatisfactory elements were based on her previous encounters with her first birth.

Complications: none

A5: Rated a 9 (would have rated a 10 but they had a trainee doing her epidural and he messed up a couple of times). **Expectations low.** Participant says that she did not have any expectations, and that she was very open; she had also heard really good things about the hospital. Complications: getting the epidural in.

A7: Rated a 10. **Expectations low.** Participant notes that she chose standard insurance to be able to keep the same doctor. He was very good at explaining things and made her feel at ease. With her first birth she had an emergency C-section, so this time she had a

scheduled one and knew what to expect. She said she didn't feel like anything was missing and everything went great. Complications: none

A10: Rated a 10. **Expectations low**. Participant started out at Ft. Sill and said the care was awful. She rated them a 5. When she moved to Omaha, she said the care greatly improved and she was very happy with the change. *Note*: previous experience was very bad (OB care at Ft. Sill), but everything was an improvement in Omaha. Complications: none

High ratings: For two of the participants (A7 & A10), previous experiences with OB care or the birthing process could be defined as scary, unsatisfactory, or less than great when compared to their current care.

High rating: Participant A5's previous experiences are unknown. We may assume that she had a better experience with her first child, and potentially no complications with the epidural like this one, but not enough is known to draw that conclusion.

Low Rating: Participant A3's previous experience with birth was one that she, more than likely, was satisfied with. When her experiences did fit with her previous experiences, she was less than satisfied.

Notes: All participants noted little to no expectations, however, in the case of A5, her previous experiences did not match her current ones, and she found that less than satisfactory. She had basic expectations without even knowing that she had them. In this particular type of service, there are certain things that may or may not be expected. Hers where obviously not met. For the participant's with previously bad experiences, they both gave higher ratings. ** When expectations, based on previous experiences, are not met

(knowingly or not), we are less satisfied. **When experiences are better than past experiences, participant are more satisfied.

Previous births: Ratings

- 2: 10, 10

A9: Rated a 10. Expectations

A11: Rated a 10. Expectations

A15: Rated a 10. Expectations

02-20-15

Thoughts and notes | reviewing the data

When patients have no prior experience, satisfaction levels are high; this could be due to the fact that they have nothing else to compare it to, meaning, there is no base level of knowledge.

The findings of this study somewhat contradict the discrepancy theory, which states that if expectations are not met, satisfaction will be lower. First time mothers who had medium to high expectations rated their care as very satisfactory, even in the face of complications or unmet expectations. **This novel theory of satisfaction (first time care theory) appears to only be consistently accurate for those without prior first-hand experiences.

Of those with previous experiences, if the past experience was less than satisfactory or about the same, satisfaction was high. When something didn't occur, that was believed to be "standard practice", patients were less than satisfied, even when stating that they came in with no expectations; the prior experiences had an effect on ratings.

02-25-16

Table 1

Participant Characteristics

Characteristic	Number
Age	
18-20	0
21-25	2
26-30	6
31-35	3
36-40	1
40+	0
Average	29
Weeks at Delivery	
37	1
38	1
39	6
40	1
41	2
Missing	1
Number of Previous Deliveries	
0	5

1	4
2	3
Type of Delivery	
Cesarean Section	3
Vaginal	7
Missing	2
Insurance Type	
Standard	5
Prime	7
Pink Team	4
Blue Team	2
Midwife	
Yes	3
No	9
Rank	
Officer	4
Enlisted	8
Service	
Air Force	11
Army	1
Hospital Rating	

8	1
9	6
10	5

02-26-16

- Still have not uncovered the "why" to the question of "why would patients NOT recommend the hospital to family or friends"
- Military wants to bring back care to MTFs (2015 initiative). If not satisfied, people are not going to come back!! Roll that into the findings about people not liking their prenatal care.
- Some participants said they didn't care for the services received through the base, but not enough to pay for services; this kind of "just getting by care" is not what is going to drive people who have already left to come back, and eventually may push people away as they see they can get way better care for just a small price.

02-29-16

Themes

1. Patients with no prior, first-hand experiences are more likely to perceive their care as highly satisfactory when compared to those with prior experiences regardless of expectation levels.
2. Patients with only one prior experience are more likely to compare their current experience solely on the last experience, regardless of stated expectations. This is more likely to have a greater effect on the patient's perception of current care

3. Patients with 2 or more prior experiences are more likely to be highly satisfied due to personalized selected care options. Because the patients have experienced multiple occurrences, they are able to hand-select the options that best work for them and feel very in control of their birth experience. This may be due to "patient inclusion" in which patients are most satisfied when they are involved in the decision making process (Ferguson & Howell, 2015).
4. Labor and Delivery are separate from prenatal care, and should not be viewed as one. In spite of participants having bad experiences with prenatal care (pink/blue teams), patients were overwhelming satisfied with the hospital and its staff.

The overall medical themes found in this study are highly unlikely to work outside of labor and delivery care, or even with routine maternity care throughout pregnancy. This is due to the nature of the care being delivered. Women giving birth have many choices that are optional FOR THEM. There are hardly any other medical procedures or care options that are left mostly up to the patient. In most cases, medical procedures and their course of action are left up to the provider. Labor and delivery care is one of the only services in which the patient can choose from a variety of choices including medical interventions and how those are delivered at almost any given time during the process.

Preliminary research suggests all healthcare is moving towards more patient-lead care, but that pregnancy is unique in the fact that a woman has many options to choose from throughout the entire pregnancy and in labor and delivery.

Standard – All women on standard were officers (expected). No officers were on prime. Only one enlisted was on standard, and she had had two previous pregnancies and

wanted to keep the same doctor. All women with 2+ pregnancies were on standard and all stated choosing it to be able to see the doctor they wanted and/or the same doctor.

Appendix J

Transcriptions

A1 Transcription

Researcher: So today is Oct 8 (2015) and we are with participant A1.

Demographics:

Dependent, Air Force, Enlisted, 26YO, 0 Previous deliveries, 39 weeks 6 days, prime, Blue

Researcher: How was your experience with the blue team

Participant: Um, pretty great, um at least leading up to birth. Now we noticed that we don't get information unless we ask for it because he is not specifically a pediatrician. Um, but so far happy with him. But that is kind of why we chose blue team, so all of us could have the same doctor.

Researcher: So you got to deliver with the doctor you saw all throughout?

Participant: Yes

Researcher: So no we'll focus on the delivery it self, from the time you checked in till the time you were discharged. If you want to just start from the beginning and go through what happened and how you delivered. I might stop you and ask a question here and there.

Participant: Yeah, ok, just let me know. I don't know how many details you want.

Researcher: If it starts to get too detailed, I will stop you and let you know.

Participant: So, starting when we walked into the hospital, or beginning of labor?

Researcher: Were you scheduled to go in, or you went in because your water broke?

Participant: My water didn't actually break. I just started having contractions. It was

Christmas day around midnight or 1. My husband got home around 3:30 am and we went to the hospital. We got to the hospital around 5-ish. I kept notes too. I wanted to eventually write a birth story. I forgot a lot of the details I think. it is kind of a time warp. So I forgot what order things happened in and I didn't realize how long certain things happened. So, lets see. We started triage at 5 am, there was a shift change that was happening in an hour, so we walked around for an hour. I was three cm when we started and 4 after the first hour. So they decided that that was enough to admit me, but there was a shift change, so they didn't want to admit me because I would be seen by one doctor and then after the shift change I would see another, so they had me wait another hour and a half, and then the new doctor kind of came in and checked and decided that we were good. So it was about 8:45 when we were admitted.

Researcher: Was this at [the close civilian hospital]?

Participant: This was actually at UNMC. We were planning on [the close civilian hospital], but I have a bleeding condition that, I don't know if you would consider rare, but just a little unknown. So I think they were preemptively treating it as a high-risk pregnancy. I didn't have any issues during pregnancy and I ended up not having any issues with childbirth at all. But it was kind of just a precaution. I had a hematologist and an anesthesiologist consult and test done. They were also there to make sure things went well. To have a game plan in case things didn't. That's why we were at UNMC. Pretty much all up until the couple hours before I was admitted we did a lot of walking because it was going to help with progression, but I was pretty tired and hungry by the time we got admitted, so at that point I kind of just gave up and I was going to spend the rest of the time on the bed. I didn't do a lot of walking after that, so it slowed down quite a bit. I

tried laboring in the tub for a while. And so a couple hours past and I wasn't dilating any further, so they started a little Pitocin, which I was definitely afraid of, with all the reading and research we did before. But they went ahead and started a little bit of that. I want to say within the next hour I was pushing and so I think it went a lot better than I expected.

Researcher: When you say it went a lot better than expected. Do you mean with the piton?

Participant: Yeah, I had just heard stories about the contractions being really strong, and close together and it just being a lot harder for labor. Especially the lead big study in hypno-birthing, and I was trying to stick with that, so I wanted to be un-medicated. Which turned out to be better especially with them not being certain about my blood condition because I wouldn't have to get a spinal tap for an epidural. So it was a little bit safer anyways, so I was breathing, and so just kind of the Pitocin without the epidural sounded kind of scary to me. I didn't notice it, and it definitely helped progress things and it wasn't unbearable. That was good.

Researcher: So would you say you definitely went in with a game plan? This is how I am going to do everything?

Participant: yeah

Researcher: And everything, besides the Pitocin, did everything go according to plan?

Participant: No, well, yes and well. We were really blessed that we wanted to do it naturally and I feel like for the most part we did that, and so that's what I wanted and that’s what we got and Oliver didn't have any complications during labor or there really was not intervention necessary, I was just getting pretty tired in the transition phase, and

that, I actually started for an epidural and they didn't want to do that at that point and so that's when they gave me the Pitocin instead. I am actually glad, looking back, that they didn't. I guess I would want them to honor my wishes, but its not *really* what I wanted.

Researcher: In the moment you wanted it, right?

Participant: Right. So yeah, if you look at it in the grand scheme of things, it went the way I wanted it to. But Rob and I wrote a very detailed birth plan and most of centered around a very serene, hypno-birthing, and that is mostly what changed as far as the plans. I even requested that I didn't want any students comings, only necessary medical staff coming in, I only wanted them there when they needed to be. Like if they were coming in to check. I didn't want to be hooked up to the IV the whole time. I wanted to be able to move around. I wanted to go into whisper and having Pandora going and I just wanted to be meditating and listening to music and just kind of be quiet and peaceful. But from transition on I was pretty vocal with labor and so I felt a little hypocritical because I had even printed out a sign for the door that explained it was a hypno birthing room and that i wanted it quiet and I'm in there kind of yelling, but in a sense it is what was helping me through labor. I do feel like I was meditating pretty well through the first part, but for the tail end, that is what was helping the most, moving around and just being more vocal. It wasn't quiet.

Researcher: At all times did you feel like you were still in control even though it didn't go according to your birth plan?

Participant: yeah. I was pretty frustrated when I asked for the epidural and I couldn't get it. My muscles were just really tired, and so I didn't think the contractions were getting worse. I was just so tired. I don't think I even realized I was in transition. Because I was

pushing not long after [that]. So I think if I would have known which stage I was in, I wouldn't have been as frustrated. I got told no, and I had asked a couple of times, and they decided it was too late, so I got told no. That was frustrating because I got told no, and I didn't feel in control because I felt like no one was doing what I wanted but it wasn't for very long. Even with the pushing, so with hypno birthing i didn't want to push, I wanted to breathe the baby down, which is something they talk about in the book and so I didn't want coaching, standing with me, telling me to push, but there was actually a nurse that came in and she got up right up next to my ear and was whispering in my ear like encouraging me with each contraction to keep pushing. I would say ow or something and she would just tell me "you can do this" " just keep pushing" and looking back that was so helpful, and I didn't realize I would want that. Based off the reading I thought I would want to do it without coaching, but I was really appreciative of that nurse that was kind of coaching me through the pushing stage. We had a couple other details but that is about as well as it went. I was really impressed, I had read a lot about skin to skin, and we went to tour the hospital before we checked in, like a couple weeks earlier, and pretty much they have the hospital policy that we had read anyway and that we wanted. We had expected to print out some sort of great plans that we wanted, but we didn't need to, and they pretty much agreed with everything we wanted to do. I was never separated from Oliver, except for once during a hearing test a day or two after he was born. I could have gone with him but I decided to take that chance to sleep a little bit.

Researcher: So your expectations going into this with the hospital, since you did a lot of research, would you say that they met your expectations or exceeded, or right about on par with what you had thought they were going to provide?

Participant: I was impressed actually. I think they exceeded my expectations. I think there was a lot that I didn't even think of that they did that was really thoughtful. I think the whole time, Rob and I were just in awe of the service of pretty much everyone. Even while we were in recovery, even just the lady that came in to clean up the room a little bit, and then the nurses, doctors, each to the specialist that we had came in and visited. It was on a Sunday too, on a weekend they came in and checked on us in recovery. They just seemed to really care about us and some of the nurses that were right at their shift change, right when I started pushing, wanted to be there so they stayed on and that was great. They even stayed on with some of the staff. Just a lot of it i didn't expect. They let me get in the bathtub with Oliver, and so we kind of both got cleaned up together. They just seemed to really focus a lot on the mother-baby relationship right off the bat. Had tons of help with nursing. I just feel like they were very attentive, and spent a lot of time with us and just wanted to make sure that everything was done the way we wanted and there were some things that we just didn't know as first time parents.

Researcher: They definitely answered all your questions?

Participant: Oh yeah. I think they were kind of picking up with the way we were talking to them that we had at least done some research, so that kind of helped them on how to direct their answers in a way that we could understand and feel comfortable. We felt like we were experts going in because we had done all the reading. I think we have been humbled [laughs].You don't realize what you don't know and with all the research we tried to do, we still didn't know.

Researcher: Would you recommend the hospital to family and friends?

Participant: Oh yeah. We actually toured [the close civilian hospital]. It was really early. I

think it was right after we had the first ultrasound. Maybe around 12 weeks, so we went to tour and their rooms are gorgeous. They have two huge windows, nice views, and it just looked like more of a hotel room than a hospital and they have a tubs. I was really excited about being able to labor in the tub, and so that was pretty important that I had a tub in the room, and then we found out that we were going to be sent to UNMC, and I was pretty crushed, and frustrated. We went to tour UNMC and sure enough their rooms were a lot smaller and they definitely looked like hospital rooms. They had tubs but they were not laboring tubs. They were pretty shallow. The recovery room had nice tubs [laughs]. I was just really bummed, and I was picturing my delivery already in the close civilian hospital, but we end up at UNMC. The other thing about [the close civilian hospital] is that you stay in the same room the whole time you are there for delivery and recovery. We were transferred to UNMC, but you know if didn't bother me the way I thought it would. It wasn't really negative the way I thought it would be. And it was still very comfortable. The lighting, the noise level was the way I wanted it, and then given our own private room for recovery was totally time. I wasn't really taking in the room as much as I thought I would be. It really wasn't all about that anyway. I was so focused on the hypno-birthing that I just wanted everything to be perfect for that so I cared a lot about the room, I think, but the service at UNMC trumps everything. It's really not as bad as I thought [it would be].

Researcher: This is a really good point and I am glad you brought it up. You got to tour [the close civilian hospital] and then going to UNMC, you were disappointed in the room, do you feel like maybe you went into the hospital with a little bit of that disappointment, or like once you got there it didn't even matter? Did you expect less because it felt less

than what you knew it could be?

Participant: [Laughs] Yes. So that was one of the things. [the close civilian hospital] seemed a lot smaller of a hospital and UNMC is like walking into a mall. There are escalators, and multiple floors and we had a lot of appointments there leading up to birth, and it was just really hard to find things there. It just felt like a mall to me. Its just this big hospital type of feel, so I just expected to be more of a number to them. [the close civilian hospital] is just much more homely and smaller and more personal and so I was pretty bummed about that, because I was looking forward to thank kind of care, but that is exactly what we ended up getting at UNMC. I was also really bothered that I saw a resident [blue team] and I told him about my bleeding disorder. I mean I have known about it for years, and I just wanted to get that taken care of it, so that we all knew about it going into the pregnancy and it was taken care of, and so he like "ok that's fine", but then he took my information to some random board meeting with other doctors, and my next appointment he holds up this red folder and says "we upgraded your color to red and you're high risk now". I was like, are you kidding me? I am trying to do this whole hypno-birthing experience and now he's over here like, I don't know. There are certain words you are not supposed to use [during pregnancy] because they are negative like when you are talking about birth or during hypno-birthing and so classifying my pregnancy as high risk um really bothered me and even just the imagery of the red folder. And then I had to go to UNMC because I was "high risk", and then it was because there were going to be specialist there and there were going to be a lot more people in the room and I just felt like it was escalating, and THAT felt really out of my control, and so I felt like I just had to fight that state of mind that they were leading me towards. I didn't want

to think of birth as something dangerous. That was really frustrating.

Researcher: The fact that they made a big stink about it and you just...

Participant: Yeah, it was just the whole high-risk category thing.

Researcher: How long did you end up staying there:

Participant: We stayed, I can't remember, it was an extra day over what they try to get you out at. I think it was 48 instead. I think that clock starts after delivery. I think we checked out on Sunday.

Researcher: Did they do any follow up calls to check up on you, like a couple of days later?

Participant: Yeah, they did. They called us at home.

Researcher: how did you feel about that?

Participant: It was not something I expected at all. Even while we were in recovery, the specialist just coming in and checking in on us and I guess they were not ever needed in the delivery so they came to see me to see how everything went. Getting the phone call, we were given a lactation specialist we could call for a couple of weeks after birth since we were having problems. I didn't feel alone. I voiced something like that while I was still in the delivery room, like I had never really healed a newborn before and he felt so delicate and I was afraid of breaking him or something. And so i asked if they were really going to let me go home with him [laughs]. I felt like as a first time mom I had a lot of support even after I went home. I never felt alone even when I needed help.

Researcher: Overall, what would you rate the hospital, given all of your experiences, like 1 (god-awful) to 10 (just great)

Participant: I usually try not be too absolute and rate things a 10, but I'd say a 9.5 at least.

I don't know. I guess I just wasn't. I didn't really know what to expect. We had done as much research as we could but there was a lot I didn't know and didn't expect that they did that went above and beyond. Especially there was a nurse in the middle of the night. I didn't understand that there was an art to breastfeeding; I thought it was going to be pretty instinctual. I actually knew a head of time someone was telling me that you should read up on labor, but you should also read up on breastfeeding, I was like... nah. And so he was so hungry, and I was trying to feed him, but it was frustrating him and he was getting even more mad and so, it was so heartbreaking. Having this newborn that I couldn't fill his needs, and so I pushed the nurse button and she came in and spent over an hour with me teaching me how to breastfed him and just realizing that I couldn't just put him on my nipple, that I had to help him. I had to teach him how to latch. So I definitely feel like they did what we didn't expect but whatever we needed there were just there as long as we needed them.

Researcher: [Wrapping up] Is there anything else you want add to this that maybe I didn't cover?

Participant: Um, yeah I think we covered everything. I pulled up my birth plan and I can email it to you if you would like.

Researcher: Yes.

Participant: [Participant talks about her plan and how she wanted to write a birth story; researcher asks what inspired her]. We read a lot of books on hypno-birthing, and I wanted more. I watched a lot of YouTube videos on hypno-birthing, and live videos. There are actually a lot of videos out there. I am thankful for because I personally don't think I would have filmed my birth and shared on the internet, but other people have and

so that was really informative to be able to watch and see it in real life, and I read any birth story I could. A lot of my friends wrote birth stories and interventions they did, and I read every single one of those that I could get my hands on. Everything you read on hypno birthing reminds you that not everything will always go according to plan, even though you want to have a birth plan, just be open to things changing because they didn't want you to feel robbed, like you wanted to have this beautiful experience and it was "ripped away from you". They wanted you to understand that there is a reason for medical intervention and sometimes it isn't going to go according to plan but it can still be beautiful. And so I kind of searched for stories so I could get a reality of what could happen instead of the ideal things like in the book. And so that was so helpful for me, and I wanted to put something up that could be helpful to someone else especially since hypno birthing is getting a lot more popular but there is not a lot of information out there as far as personal experiences on the internet quite yet.

Looking back I am happy that I needed the Pitocin. Looking back I thought it was the devil and that I should avoid it at all costs so here I am begging for epidural, but they say, no, but you can have Pitocin, and I don't even know what to say because I didn't want that at all, but I realize I do need help, so they end up giving it to me and I was expecting terrible, horrible labor but then I ended up dilating the last two centimeters and got to start pushing and so suddenly I went from being terrified of it to having this healthy respect for it and realizing that there really is a time and place for it. It can be really a blessing at the appropriate time. Medicine is there for a reason and I really appreciated having it there at that moment.

Researcher: Did they really have to convince you or?

Participant: I was so immature. I went from begging for the epidural, to them telling me that I could have the Pitocin, and then every time they mentioned it i pretended that I couldn't hear them, like I was focusing on breathing or a contraction or something else, because I did not know how to answer that question. I realized that it was probably the right thing to do but I did not want to say yes. They asked me multiple times and I just ignored them [laughs]. I remember my husband finally saying, yeah lets just start it. So I am glad he did because I wasn't willing to say it. It is not as bad as it is made out to be. They do really make it sound evil. It is meant to be used in a certain way.

Researcher: I want to go back really quick before I let you go. This is all with blue team and the medical care you received with them. Is there anything; was it really good, really bad, parts that were good, parts that were bad?

Participant: Um, I think its all pretty positive. I was kind of nervous; I didn't understand the concept of resident doctors. I guess before that experience, I realized that they have been through medical school, so they are very educated, but they are not quite as experienced, so I was a little nervous about that, but we are LDS and the doctor we were seeing happened to be LDS, so we shared religious views, so it was comforting on that level. and then he was very quick to ask questions. If there was anything he wasn't 100% sure about he would go ask higher doctors, just to double check for us for answers that satisfied our needs. Even if he couldn't have the answers right then and there. He was really honest too. He wasn't going to make something up. I was really embarrassed when I went to tell him that we were going to do hypno-birthing and he was like "wow you guys are brave, but yeah sure, ok". He really supported us. Very willing to listen to what we wanted and work with us on what we wanted. We walked in feeling like we

understood each other because of our faith and it was a great way to start the doctor-patient relationship.

Participant A3

September 25, 2015

Demographics: dependent, Air Force, enlisted, 31YO, 1 previous pregnancy, 39 weeks 4 days, prime, pink team.

Researcher: With the pink team, did you see one or was it a rotation?

Participant: I saw about three to four of them; I could not tell you who they were.

Researcher: So I have a couple of questions, the first one you just tell me about your birthing experience from the time you got checked in to deliver to the time you checked out. Anything, you can run through the whole thing, you can tell me what stood out to you, what you liked, what you didn't like.

Participant: Oh my goodness, ok, um I guess more of my issue was with [the close civilian hospital] medical than it was with the [local base] team. I had a scheduled cesarean section so we got there checked in, awesome, loved the hospital, its great, doctors and nurses were good. We went in, had everything went perfect, as planned, got the baby out, my husband had to go pick up our oldest from school so I was left there by myself. They held the baby at my face the whole time, which was beautiful, but then got done closing me up, put her on my chest, wheeled me to my room and left me in the room. I couldn't feel anything from my armpits down, and I had a baby to take care of, and no one there. I found it very odd that they didn't have a nursery. I don't know if that was a normal thing here. When I had my daughter, we were civilian, and they asked me if

I wanted her to stay with me, or if I wanted her to go to the nursery, they took her to the nursery. When I wanted her they would bring her back in. I got to sleep and rest and recoup. Nothing. My daughter stayed with me the entire time. I was only in the hospital for 48 hours after the C-section.

Researcher: Did the hospital kick you out, or did TRICARE?

Participant: No I chose to go home because my husband was with our daughter, who at the time was only two and a half, and she couldn't stay at the hospital very long because she would start getting into things and start running around and going stir crazy, and I just had more help at home then I did at the hospital, because I just thought it was so weird. I was going to stay the full 72 hours you know, I thought this is going to be a little vacation and get to rest before coming home to the chaos, but no I was flabbergasted that they just handed me my baby. I couldn't get out of bed, I couldn't move, so it was either hold her or call them every time I needed to pick her up. She was there screaming bloody murder and I couldn't get to her, I had to call them, so I just held her for a good 13-14 hours. But, other than that, I mean, I just thought that was odd, but it was a good experience. I am weird, I loved my C-sections. Everyone says "you were so robbed", but I don't feel like I was. I loved it. Everyone up here tried to convince me to do the v-bag, but I was like, no, I don't really think so. And my husband and I also made a collective decision to formula feed our second one because I tried to breastfeed with my first and it was horrible, horrible. He said "let's not even go through that again", I said ok. The doctors were really, really pushy about that issue. I know it was in my chart because I saw them write it down that I was formula feeding. Every time a new nurse or doctor came in, they'd be like "so your breastfeeding?". I was like, no, no we are not. [They

would say] are you sure you don't want to reconsider? [I would say] yes, I'm sure. So by the time I'm getting ready to go home I was in tear, feeling like I am a horrible mom because everyone and their mother had asked me if I was going to breastfeed, so I tried and it was horrible experience again. We tried to do it for three days. It was the worst three days ever.

Researcher: Was it the doctors at [the close civilian hospital] that were pushing you to do it, or before?

Participant: Both. When I was seeing, it's so strange, when I was going to my OB appointments, they asked and I said I was formula feeding. I don't remember the woman, it was the older lady that asked me; and then when I delivered, a younger doctor that I hadn't seen did my c-section, and she was very pushy about it, and she was a doctor here at [the local base]. I don't know what she is, but she is in the military. It wasn't a civilian doctor or anything, but she was very adamant about it as well. But then the pediatrician came in and he was also, [the local base team], never even once batted an eye as was like, if that is what you want to do, do it, so he was awesome. And it seemed to be coming more from the women there. I mean, other than those two things, I loved it. I really did.

Researcher: Did you have any expectations going into it, having had had a child before? Did you go "I know what's going to happen; I'm going to do this"?

Participant: Yes, I did. Like I said, I expected them give me the face to face time and the skin to skin contact while they were sewing me up, because that is what I did with my daughter, and then I thought they would take her to the nursery and let me get some rest since I was doped up "so to speak". I did expect that, and I guess I should have asked what the procedure was so I would have been a little more informed, but I don't know. I

guess I thought it was the norm because we never delivered being military but that's the norm up here. I was talking to a friend up here about it, right after wards, and she gave me the "[gasp], you wanted them to take your baby away". Yeah, I wanted to sleep. I had a toddler at home. I wanted to sleep. I think that was the one expectation that I had that I guess I shouldn't have? The only time they ever took her was to get her hearing test done, and the nurse asked if I wanted them to just take her up to the nurses station and they could just hold her for a couple of hours? I was like, yes I guess. They had just given me a Percocet, so I was like since you just gave me a pain killer, that would be awesome! So that was the only time she was ever out of my room.

Researcher: And you said your other one, you delivered while you were civilians, right?

Participant: yes.

Researcher: Where was that at?

Participant: It was in Texas.

Researcher: Were there any other differences, besides them not taking her, than your expectations. Like if you expected certain things; was that the only one where you went in thinking "this is probably going to happen" and it didn't, or wasn't prepared for something else that did happen?

Participant: I don't think so. Everything else, um, was pretty mush the same. We induced with my oldest, so having a C-section was kind of a shock and kind of a rush. So i really didn't know what to expect I guess expect for the whole procedure part.

Researcher: So you didn't schedule the C-section previously?

Participant: No, with the first one it wasn't scheduled, but with this one it was. And the only reason I did is cause I was nervous going in. I hadn't known anyone who had had a

C-section, so when I had my C-section with my first, and it was beautiful, and went smoothly, it was like, I am going to do it again. And it was just as great the second time! ***They also had to switch me rooms because there was such an overflow of people delivering. I ended up having to go to up or down a floor, but it was the non-secure floor.*** We had a guard, a little old man; he was the cutest thing ever. I don't know what he was going to do. So I did have to switch rooms after 24 hours. I forgot about that. That was quite an adventure.

Researcher: Overall, what would you rate your birthing experience? With the hospital overall?

Participant: With the hospital overall? I guess overall, it was about an 8. I would say about an 8. It wasn't bad. If I had to do it over again I would have asked and made sure I was better prepared, but no I mean the staff was really great and I really didn't have any issues. Anything I needed, they did for me. So I mean it was different, but it wasn't bad. Cause, just depending on what you are looking for. Most people like to have their babies right there, I mean if that is you, then great, but not me.

Researcher: So would you recommend the hospital to family and friends?

Participant: Um, Yes with the disclaimer of how things are done. But yes, I mean I did like it there. It was a nice hospital.

Researcher: Had you heard things about it before? Like from people in the community, or other friends.

Participant: It's kind of a toss up between that and I may say this wrong, [says hospital name]. The reason I chose to stay prime and go to [the close civilian hospital] is because I had a tubal ligation after mine and I knew that [the further away civilian hospital]

wouldn't do it, since it is a catholic hospital. ***So, that was one of the deciding factors for staying prime***. And delivering at [the close civilian hospital]. We are done.

Researcher: Ok, thanking back to pink and blue, and being at [the local base], did you do your entire pregnancy at [the local base], or did you do part of it as a civilian?

Participant: Yes, I did do the entire thing at [the local base].

Researcher: How did you feel about your care, other than them being pushy about the breastfeeding, how did you feel about the care you received through the base.

Participant: With it being pink team, and seeing different doctors, I didn't feel as connected, i guess, as I did with my first one. Having the same doctor the entire time. So that was... I wasn't too happy about that, but I would rather have had pink team and actually had doctors than have blue team and having residents. I wasn't comfortable with that either. So it was rock in a hard place type situation, but I liked the doctors that I saw. Some days I felt like I was just kind of herded in and out, let's measure you, and make sure you're ok, and get you on your way. I don't know if it was because it was my second pregnancy, and they thought that I knew what I was doing, but my second one was completely different than my first one. COMPLETELY different, so I had a lot of questions and some of the doctors, I felt like [they were] annoyed almost [and I was] taking too mush time. It was only a couple of ones. It wasn't all of them. The one that I made sure I made sure to make my appointments with towards the end, I really liked her, and I thought that she was going to deliver, and then it ended up being someone else. But, other than that, it was good. I had gestational diabetes with both of my girls. I felt like, being civilian, or maybe it was just being back home, but I feel like they watched it a lot more. Like with how big she was getting and stuff. And here they didn't seem too

concerned with how big she was. I guess because I was just doing a C-section. I don't know, but my second one ended up being 9.3. So I am so glad she was a C-section. ***But it wasn't... it was just different. I guess because I didn't have that connection with the doctor. But I know if I would have switched to standard I would have had, but to be honest, me and my husband and I talked about it and [we decided] why pay for something when you don't have to if you're getting the level of care you feel is adequate for you. So he is like, as long as we don't have a problem, and everything goes smoothly, he was like why pay for it.*** That's another reason we stayed prime during the pregnancy because I didn't have a very complicated pregnancy and didn't have any issues, and [we] didn't feel the need to do something else.

Researcher: How would you describe the communication between them and you? On both levels too: Before with the base and at the hospital?

Participant: Um, hum, the communication (i thought) was great on my end. They were really quick to respond when I had questions or concerns. I was super clumsy, so I fell a lot during my pregnancy, so I was calling them a lot. They were always quick to respond. Even when I would write them on the *MyCare* system. Within the end of the day they had answered back to me. Which was really nice too. So I did like that they had that available as well. Because you know, with my other one running around, I didn't always have time to stop and call and wait, or go through the prompts; I could just shoot a real quick message over, so they were really good about responding. Responding back to me. What do you mean by the hospital?

Researcher: So they should have, well, they had an opportunity to communicate to you about what would happen after your C-section, which they didn't communicate about

your baby not being able to go to a nursery. Is there any other instances like that you felt they didn't communicate something to you, during the time?

Participant: Um, I think it kind of would have been nice to know before I had my daughter there that I wouldn't have been able to stay in the same room. Because I did have to shuffle by myself, because my husband was at home taking care of our daughter, have to move me and the baby, and all of our stuff, just to go upstairs, to leave within you know 14 hours, again. I wish that would have been communicated to me before we got there. Which I know that can be hard, because women pop into labor, normal people do. and don't plan everything like I do. So I guess that one really couldn't have been helped, but it still would have been nice to know a little more than Hey, we're switching your room in like 5 minutes. Other than that, it was pretty good. I feel like they told me just about everything else.

Researcher: Did you go into with a birth plan?

Participant: Other than have the baby, nope. Even with my first one we, "murphy" is a big friend of ours. You know, what ever can go wrong will, that's us, so when it comes to stuff like that, we try to plan, but we didn't have one. Just have the baby. With the first one we did have a "plan", I was going to do it naturally, I was going to have her and it was going to be beautiful and no interventions, and I was going to watch it. nope. After the first one, I was like, no, not even having expectations for anything.

Participant A4

September 25, 2015

Demographics: Dependent, Air Force, Enlisted, 36YO, 0 previous deliveries, Delivered at 39 weeks and 1 day, prime, blue team. Pcs'ed when 24 weeks along.

Researcher: What we are going to focus on is from the time you delivered, till the time you checked out. So on prime, did you deliver at [the close civilian hospital]?

Participant: Yes.

Researcher: Just go ahead and tell me about your experience, anything that really stands out in general. There are only really 2 questions. The first one is tell me about your birthing experience, and then the second one is looking back before you delivered, what were your expectations going into it, and how did that differ from what actually happened. Like if you had a birthing plan, and you actually didn't stick to it.

Participant: No, no plan. How I look at it is my age, I'm pretty, I mean, I was 35 at the time and I already had nieces and nephews and I was pretty.... Nothing goes according to plan, whatever you want, so I was more laid back, open. I did take the birthing class, by husband and I , at [the close civilian hospital], so we did the hospital tour; we did the birthing class. I think that was like 4-5 hours, just to get an idea of the labor, which I didn't even know you had to push out a placenta. I was like what!? You gotta push twice!? So, the class was helpful, even though i knew how to change a baby and that I had actually before done the lactation. I actually got in touch with them because I breastfed. So I didn't really have a plan, because you can't really control. They want you to have a vaginal birth first, so you can't really say, alright, my water is going to break or it's not going to break. I just went with the flow and I just got my check-ups when I did and they told me if I was dilated, and I never dilated. So I really wasn't too stressed till 39 weeks, when I was like, ok this has to happen. It's going to happen either way, so. I

was pretty laid back. I had her on the 4th, so on the 3rd of September, my water broke. Actually I knew I was going to have her any day. I told my husband, I'm like, we are having her by the end of the week. My water broke Wednesday night, at three in the morning, and then I got my husband up (he got up and took a shower). He was panicked. He hadn't packed, I wasn't, I had my bags packed. I really wasn't worried. I was like, just get in the car and drive me. We went to the hospital about 3ish. I had already called before because they said to call to make sure there were beds and just to give them the heads up. I called and there were beds. Once I got to the hospital they just asked we had to double check that your water broke. I can't remember how long that process was. They got me in a room Polly within 15 minutes. It wasn't long by the time I had filled out, signed some forms, gave them my ID (researcher: so reasonable: yeah, it wasn't long at all). So maybe 10-15 minutes I got a bed. It was just more filling out the paperwork.
Researcher: Did they give you the option before, to fill out the paperwork?
Participant: No. I think it was the consent form? I am not sure what forms I signed, I assume it was the hospital consent, stating I can give birth there and everything's going to be ok. I don't remember what I signed honestly. I'm like, just give me the paper, where do I sign. [the close civilian hospital] was very, I had a great experience there. They were very nice. After, it probably took them about an hour to figure out my water broke, and the test and everything. It wasn't that long in the scheme of things. I can't remember the exact time, and then I never dilated, and then about 7 in the morning they said they were going to give me the Pitocin because I wasn't dilating or nothing. My contractions weren't even. I couldn't even feel my contractions at this time. Even though I was having them, so they actually were nice, you don't know one when you are going to have this child, it

could be tomorrow, lets have you eat something, so we got some breakfast. They couldn't give me any food after that, so I think at 8am I took the medicine and then I made it till about 11am and then my contractions started getting stronger and I got dilated to 6 or so, and I couldn't handle the contractions so I finally gave in and got the epidural (after the pill). That kicked in about noon and then from about 12-4 I kept slowly dilating, and then at 4 I got to 9, and then said at 5 you are going to start pushing. I think you will be at 10 by then. I told him, well here is the problem, I don't feel my epidural anymore, my legs, I could feel my whole legs. He said ok, well either way you are pushing at 5. I said ok. So they brought the doctor back in and they realigned the epidural and couldn't get it to work. They said some people it just doesn't work, but at 5 I was pushing either way. So I could feel the whole delivery. I am glad I didn't have a plan, because I actually had a panic attack, because I wasn't understanding how this child was going to come through me and I was going to feel everything. So at 5 pm I started pushing and she didn't arrive till 6:38... so I pushed for and hour and 38 minutes of pure pleasure. All my friends are like, I only pushed once or twice, I was like what? I pushed like 25 times, and I felt everything, so! I had an easy birth after I had her, when the doctor, I actually had a civilian doctor deliver me. I don’t know why, but I did. The military doctors came in earlier and then they came back the next day, but after the doctor tried to pull my placenta, because I couldn't push it, it wouldn't, I just, I don't know why, so when he pulled on it, he pulled the cord too hard and it like, I don't want to say exploded, but it disbanded in uterus. The doctor then couldn't get it out cause you can't use tools or anything, so he had to put me under for an hour and a half to manually remove the placenta. My husband said it was the most disgusting thing he ever saw because he was

holding out daughter, watching it and he said the doctor pretty much took his whole hand up to his elbow and was like digging. My husband said he didn't even know you could do those kinds of things. I cried more during that then I did the birth cause that was so much worse, but other than that, I had a great experience.

Researcher: The doctor who burst your placenta, was that the civilian doctor.

Participant: Yeah! They said it happens, I guess.

Researcher: Overall, you were, would you say you were really happy, or just kind of.

Participant: Yeah, really happy. I would give it a 10 out of 10.

Researcher: Is there anything, if you could change, that you would?

Participant: No, just the placenta thing, but you can't control that, but I couldn't, the only thing I would change is cause I couldn't hold my daughter because I was in so much pain and she was so slippery, I couldn't focus because of what was going on, but you can't control something like that. Nothing medically. I would say because they were wonderful.

Researcher: Did you have, I know you said, and we talked about this, and I know you really didn't have any, real expectations, and you were real open, um in the end though, do you feel though, do you feel it went how you imagined it would go.

Participant: I thought I would have an epidural. I didn't think I would feel it, from all my friends. I do think that all my friends who did natural, that was their choice. I didn't have a choice, but that's something you can't control and I'm glad that I didn't have a game plan. I think more people with game plans, are to me, are more uptight people. I had a wonderful pregnancy, I loved being pregnant; I worked out, I traveled, I didn't get morning sickness, but I also think that has a lot to do with my personality, and I'm easy

going and I don't stress about things. Yeah, if I thought something was wrong with the baby, I went and got it checked out, but I tried never to stress. I think it is your personality, because I am easy going with my daughter and she is a wonderful happy child. So I think it all depends on how you are. And they feel your energy.

Researcher: Would you recommend the hospital to family and friends?

Participant: Yes!!! Yup, I would!

Participant A5

September 25, 2015

Demographics: Dependent, Air Force, enlisted, 29YO, 1 previous delivery, 39 weeks at delivery, prime, pink team,

Researcher: Can you clarify about the doctors? So you only see one or two?

Participant: No, you see multiple doctors, but you can request to see a specific one.

Researcher: Tell me about your birthing experience, this is from the time you checked in till the time you checked out. Labor and delivery.

Participant: Overall I thought it went really well, and really smooth. He was scheduled because he was really big so they induced me. So my induction was scheduled for April 12th at like 9pm. I wasn't in labor when I walked in.

Researcher: Was this at [the close civilian hospital] Medical?

Participant: Yes. And I overall, I thought it was really nice. I thought the nurses and everyone did a really good job. I mean they described what they were doing. How the induction was going to work. And I thought they were very quick in response to everything.

Researcher: So you definitely felt informed?

Participant: Yeah, I think they did a really good job. I mean I had never gone through an induction before. I didn't know what they were doing. They basically described it like a balloon. I had no idea how it worked. I have never had one.

Researcher: Looking back before you delivered, did you have any expectations going into it because you had previously had a child? Or did you have any birth plans or feelings on how it was going to go and did that differ from what you thought?

Participant: I would say other than psychologically expecting him to come at like 35 weeks, and not showing up till due date, I really only had that expectation. I've heard really good things about [the close civilian hospital], the medical center, at least the hospital. I would say my only really complaint was with like the clinic, like the actual going to see my nurses and doctors leading up to my delivery. I mean I thought everything went really smooth, and I didn't have any problems, OH, maybe the only issue I had was the girl who did my epidural. They had a girl that was in training to do it. They didn't describe that the girl who was actually giving it to me was the girl in training, and so she kept jabbing me, and so the nurse had kind of pulled my husband aside to say if she can't get it in to tell them to stop. because it was hurting me more to get the epidural in. Yeah, but once I got it that was nice.

Researcher: So would you say then, you were pretty open to what was going to happen and kind of just go with the flow?

Participant: I didn't really go in with an expectation cause I understand you don't really know how your birth is going to really flow, so I didn't really have any plans with my first, I just figured we would wing it with the second too.

Researcher: Overall satisfied with your delivery, would you recommend it to family and friends?

Participant: I would recommend them, yeah.

Researcher: If you had to give them a score on a scale of one to ten, with 10 being the best, what would you rate them?

Participant: I mean, aside from my epidural, I would say I guess maybe a 9, that is the only thing debunking it from a 10. The doctors were always really quick, the nurses were really friendly, and I absolutely loved that they had a 24hr food bar. It was really nice, especially when you deliver in the middle of the night. I didn't with him, but if I would have it would have been nice.

Researcher: So you did mention though that your only complaint, outside of the delivery was the doctors and nurses in those appointments. Could you elaborate on that?

Participant: I felt like a lot of the doctors were just not very informed, or on top of stuff. You know, a big issue we had, you know because I was having a lot of ultrasounds done, they had a growth ultrasound at the clinic. They had scheduled that, they didn't explain to me that I needed to call. They just said have it done, they didn't explain that I needed to set it all up i guess, so I had no idea I was supposed to have it done before my next appointment. I just assumed they would call me so when I called them I had to get it all set up and then we went down there and my husband was expecting to go with me and they wouldn't let him in the room. And that was just a huge, i think, I just thought we are lucky he is not deployed all the time, but you know, if this was something where he was deployed, and that would have been his only ultrasound, I can see other families getting really upset over something like that. With the pink team you get to see many doctors, but

I finally got to a point where I only really wanted to see one or two particular doctors because the other doctors were not very, I just didn't feel informed, and just really didn't know what was going on. I didn't feel like, what they were asking me, they just didn't cater very well to what I wanted. Another issue I think I had with them, was at his 20 week they had found a cyst in his brain and they never told me. They passed that information along to my doctors and my doctor never mentioned anything to me. So, it was a student and he was reading about the cyst, and I told him there was no cyst, and he said yes there is a cyst on the brain and you should never tell an emotional mommy that. And I had no idea, so then one of the doctors who was just coming back from leave she comes in because she had to basically explain it to me, but the doctor that I had seen at like a two weeks before had not mentioned it, not once, that that was something even that they had found. So even though it is not considered something serious, I feel like that is something they should have mentioned. So then they ended up having to send me for more ultrasounds for that. So I guess that would be my biggest complaint with them on that issue, and then they wanted me to take extra shots of progesterone because my first came early.

I will say that I that I liked that [the close civilian hospital] was really good about calling. They called me to make sure I was doing ok a couple days after I had the baby. Like personal touch, just to make sure I was doing ok, the baby was doing ok, at home. I thought that was just, I felt like that was going over and beyond what they needed.

Researcher: Was the discharge completely easy when you were signing out and everything?

Participant: ***They were very on top. I could have stayed a day longer, but their beds were just so uncomfortable, and I complained about that. My mom asked me, are you sure you really want to leave early, and I was like, yeah I rather just sleep in my own bed. I don't want to sleep another night in this bed. I can't complain other than that. Overall we had a good experience. I didn't have as many complications as I did with my first. I had kidney stones with my first, and those took two weeks to get diagnosed.*** I think that is what lead to her being premature, and I told my doctors that, and I understand they can't say, yeah that is for sure what caused me to go into labor prematurely but I feel like it was a very good, it played a really big part in it. It wasn't pleasant.

Participant A7

October 5, 2015

Demographics: Dependent, Air Force, Officer, 32YO, 1 previous delivery, standard

Researcher: Can you explain why you chose standard?

Participant: My husband and I, this is both of our second marriages, so this is our first child together, so I already had doctors and stuff that I liked and was not married to a military member before, so I just wanted to make sure that I could keep all of my same doctors, and nurses, and hospitals and everything.

Researcher: Since you are on standard, you went with an outside OBGYN? Where did you deliver?

Participant: Yes. I delivered at Lakeside Hospital

Researcher: So you had the same doctor and they delivered for you?

Participant: Yes

Researcher: What I want to focus on is your birth experience. From the time you checked in, to the time you were discharged. So if you want to just tell me what it was like, how it went, and everything. I will just be listening and I am going to write.

Participant: I probably don't have a lot to tell. I was a scheduled C-section, so I went in the morning and she was born in like an hour and a half. I am sorry, this probably isn't the best.

Researcher: Since you were going in for a scheduled C-section, was your first one a C-section?

Participant: It was, it was an emergency C-section.

Researcher: So then you knew. Did you have any expectations going into this second one, or were you like been here, done that, know what's going to happen?

Participant: ***Um, no I mean I definitely was more nervous because it wasn't scheduled the first time so my first experience was crazy***. And then this time I didn't really know what to expect because I had never just gone in this day and had a baby. It was the way to do it for sure!

Researcher: So, nervous going into it, do you feel like your doctor explained things well enough, or even with that you were still nervous, or maybe you felt like you didn't have all the information?

Participant: No, I think my doctor explained everything great. And you know, I was fully prepared on what to expect when I got to the hospital, I think it was just like having any baby, the nerves, but no, I knew what to do, what time to be there, what all was going to happen when I was there. So that part was fine.

Researcher: And then you are happy with your doctor and nurses and all that, and the whole process. Was there anything you would have changed?

Participant: No, I loved every nurse I had. I love my doctor. That is the whole reason I wanted to keep him when we got married. Everything was awesome. I had really great, great care the entire time I was there. I don't have any constructive criticism at all. I think it helps that I was on standard. I really liked being able to see the same person all the time.

Researcher: Would you recommend the hospital to family and friends?

Participant: Absolutely

Researcher: On a scale on 1-10 what would give it?

Participant: Um, I mean I would probably say a 10. I don't think there is anything they could have done differently. Or that I felt like I was missing at all.

Participant A8

October 6, 2015

Demographics: Dependent, Air Force, Enlisted, 21YO, 0 previous deliveries, prime (pink)

Researcher: How did you like that [in regards to pink team]?

Participant: Um, they were overall pretty good up until the end. Well at my 38 week appointment, they suddenly said I was measuring so small, and my daughter was measuring so small, so somewhere along the lines someone wasn't measuring correctly, because within two weeks, because I got checked at 36 and then at 38, so I wasn't. So

someone wasn't measuring right, and they were talking about inducing me, so there might have been miscommunication or miss-measurement.

Researcher: So thinking back on the delivery, from check in to check out, how was it, like can you explain what happened? Where you scheduled to go in, and then you can just go from there.

Participant: With the delivery, I went in at 9:00 on Saturday night, I was 6cm dilated. My contractions were not coming consistently, so they sent me home, and three hours later I went back and I was 10cm dilated, and when they took me into triage, immediately my water broke, and I felt the need to push. They took me into a delivery room and I pushed for an hour without the epidural. Then they gave me the epidural, I slept for an hours and a half, then pushed for another 45. Baby came out, placenta did not and they had to go digging for it.

Researcher: Did that go ok after they went in and got everything?

Participant: Yeah, it just took 20-25 minutes, which they said was abnormal, and they said they were concerned about the amount that I was bleeding, but luckily, eventually they got it out.

Researcher: When you went in and delivered and did everything, was it as you expected? Did you have some expectations going in, like it is going to go this way, or did you have a birth plan?

Participant: Yeah, I mean my only expectation was that I was going to be able to get the epidural before I had to start pushing and like that almost didn't happen, and I had to feel what it really feels like to push a baby out without the epidural, so no, it didn’t go

according to my expectation. It's fine though because I asked for a popsicle and I at least got that, so it was fine.

Researcher: How were the doctors and nurses, and staff and everything?

Participant: They were fantastic and supportive!

Researcher: Where did you deliver at?

Participant: [the close civilian hospital] Medical Center, Which is not Nebraska Medical Center- [the close civilian hospital]

Researcher: Overall, would you recommend the hospital to family and friends?

Participant: I would recommend the hospital

Researcher: And thinking about that, what would you rate the hospital overall on a scale of 1-10?

Participant: I would give them a 9 because the resident sent me home, when I was 6cm. That is the only thing. Ugh! My contractions never came consistently though, a***nd I had to tell them that they never came close, but how would I know, I had never done it before.*** **So I didn't know what to expect.**

Researcher: Going back even further, with the pink team, before delivery and appointments, you had mentioned the only thing was the measuring. Is there anything else that you would say about them that you did or didn't like?

Participant: The only thing that I did not like was that when I would ask certain questions about the third trimester, and let's say I was in the first or second, and when we would start doing certain things, when we would start testing, or x, y, and z, they told me, instead of answering the questions, they just said don't worry about that yet.

Researcher: So did you feel maybe a lack of communication or lack of willingness on their part to sit and take the time to do it?

Participant: I understand that they didn't want me to be dwelling that are not now, but I wanted the knowledge so perhaps I felt that they were just dismissing me, but other than that they were all fantastic.

Researcher: Is there anything else that maybe throughout the whole thing, including delivery, that you might have had an issue with, or that you thought was really exceptional?

Participant: When they did measure me incorrectly, they sent me down to radiology, then they sent me to the hospital, then they sent me for a third scan at a neonatal specialist, so I appreciated them being so through in making sure that she was progressing in the womb and in immediate danger by not being delivered.

Researcher: Just one more thing. Did you have, besides the epidural, did you have any other expectations going into it besides "I am going to go in, have an epidural, and have a baby"

Participant: I'm telling you, just the popsicle and the epidural [laughs]. I told my mom that I want a popsicle and an epidural, and everything else can just happen. Oh and the expectation of having her vaginally as well and I do know one of the girls in our birthing class, she ended up having a C-section and that wasn't in her birth plan. (birthing class thought [the close civilian hospital], and did a tour with three other military spouses).

Participant A9

December 21, 2015

Demographics: Dependent (was AD), Air Force, Enlisted, 26YO, 2 previous pregnancies, 39 weeks at delivery, standard, UNMC

Researcher: Just go through your experience and from the time you check-in to the time you left.

Participant: Ok, so my doctor, I saw Catherine Benning at the Olsen center through UNMC. She is who I have gone through for my other pregnancies, so it was nice to have that continuity. So, I think I started seeing her around 10 weeks, and I don't know everything went really well with it. I have had problems with pregnancies before. My first pregnancy was a stillborn, so I like her a lot because she took a lot of extra precautions for me, so once I hit I had the problems at before, she started doing the ultrasounds like twice a week. And then I did ultrasounds like once every month to make sure he was growing the right way. SO everything went really great, and for my delivery, I was delivered at 39 weeks, they induced me a week early just to make sure everything would go ok, but I had a really great experience, so I love my doctor.

Researcher: And you said she delivered your last two?

Participant: The first one, when I had my stillborn, that was on base. Because I worked at the clinic, but that was the one that I had problems with. Then she say me with my other son, westly, that pregnancy went real smooth. It pretty much went the same as with this one. We pretty much did the exact same thing. So everything went really great.

Researcher: Ok, so then let's think about the second one. When you had your second child, did you go in with any expectations, or were you just like "whatever happens, happens"?

Participant: Wesley, there was some anxiety with that one because of having the problems I did before, and that's one of the reasons I didn't go on base, because I felt like on base. It was a young guy, he wasn't bad or anything, I am not trying to talk bad about him, but I just don't think he had a lot of experience, so and that's why I decided to go off base with my second. For one I felt more comfortable with a girl than a guy, I wanted a girl to do it, and I liked her a lot, She has been around for a while, and her husband is in the military, which makes things a little easier because they are familiar with the process. She had a lot of, like whenever I went in for my delivery, my water had broke before hand, so she wasn't on call that night, she knew I had anxiety because of the problems before, so she took that extra step to come in, even though she didn't have to. That's why I went back. It seems like such a little thing, but...

Researcher: So with your third one (Matthew), did you feel less anxiety because you had her again?

Participant: Yeah, because I kind of already knew what to expect since I was going back to the same person, so I could go to the same place, so I knew the routine. I loved it, and I had a great experience with it, and I had no problems what so ever.

Researcher: So, overall would you recommend your doctor and the hospital to family and friends?

Participant: Oh yeah!

Researcher: On a scale of 1-10, what would you say was your experience?

Participant: 10

Researcher: I just want to confirm that your primary reason was to be able to choose your doctor

Participant: yes

Researcher: So did you have natural with both? C-section or vaginal?

Participant: Vaginal with both

Participant A10

January 12, 2016

Demographics: Dependent, Army, Enlisted, 27YO, 1 previous pregnancy, 39 weeks 2 days at delivery, prime

Researcher: Wasn't stationed at [the local base], but delivered there, and you used a doula and a birthing center?

Participant: I used a mid-wife and it was at the hospital (further away civilian hospital)

Researcher: So when choosing your mid-wife, did you go though the system and chose one, or did you know who you wanted?

Participant: I went through and looked at people who were covered [by the insurance]. She was the first one I met with and we just kind of clicked, so it helped.

Researcher: So with your first one did you use a mid-wife as well?

Participant: The mid-wife attended the delivery, but she was on call, so I would have if I could have but they wouldn't let me. So an OB delivered

Researcher: And there is a reason you went with a mid-wife to begin with? Or after the first one you knew you had to have one?

Participant: With the first one I had an OB that I liked so I didn't switch to the mid-wife early enough for me to do the delivery with them, so I kind of talked to her and doing some non-stress tests, and in the office but she wasn't my official provider, but she did do

the delivery. And I knew I wanted a midwife, and it really wasn't an option on fort sill, except if you were lucky enough to get it, but yeah I knew I wanted a mid-wife, so I actually started the pregnancy with the mid-wife that delivered my first and then we moved to [the local base].

Researcher: The mid-wife this was your first and she delivered your first and then she came to [the local base]? Could you clarify?

Participant: I delivered with the mid-wife with my first just because she happened to be on call and I requested her. So the OB did the care and the mid-wife was able to be there for the birth.

Researcher: How would you describe having and OB and having a mid-wife? DO you feel one way about one versus the other?

Participant: They bounced me around the OB practice for the last 6-8 weeks of my first pregnancy so I saw different providers who wanted different things and who wanted to induce me early and all sorts of other things, so lots of interventions that I had to argue not to have, which is why I was talking to the mid-wife. So the delivery with her was great, and the OB was out in the hallway saying he was going to C-section if she didn't get this baby out, so I feel like I had to scrape by and get everything. I was on tenterhooks waiting on that one because I didn't know what I was going to have to fight, waiting till the last min to go to the hospital. So, having mid-wife care from the start this time was so much better. I could go to my provider and as ask a question and trust the answer, not have to Google after my appointments. I didn't feel like I had to fight for what I wanted.

Researcher: So if you had to rate the OB care versus the mid-wife care, on a scale of 1-10 what would you give each?

Participant: OB care: 5, which is better than I would give the guys I saw at the end, but for most of the pregnancy was great, but he left 6-8 weeks before I delivered, and for the mid-wife 10 to 11. I would definitely set this up for future kiddos. No questions!

Researcher: As far as the hospital, did you feel like the environment was good, that everything there, the nurses, everything before and after, how did you feel about that?

Participant: Yeah, in general I didn't really have any particular nurses that stuck out as worse or anything, and the mid-wife did most of my care anyways. The nurses were helping her, but she was with me. Yeah, the after care was great. Lactation was kind of lacking and that was kind... lactation could have been better.

Researcher: Going into the first pregnancy, were your expectations different than what actually happened?

Participant: That is a long time ago, but I had never had a midwife, and since I liked my OB I stuck with him, so if I could choose again I would go with the midwife, but I ended up getting what I wanted in general because I had her and I got to talk to her, so yeah.

Participant A11

January 20, 2016

Demographics: Dependent, Air Force, Officer, 28YO, 2 previous deliveries, 37 weeks 4 days, standard

Researcher: We will just jump right into it. I know you had a water birth with this one. With your other two, did you water as well.

Participant: I did with my son [second one], and my daughter [first one], was born in a hospital.

Researcher: Those were with, were they doulas or mid-wife?

Participant: Mid-wife. Doulas can't, unfortunately, deliver. Most people get confused by the two.

Researcher: So the mid-wife, you had with the second as well?

Participant: Yes, same one.

Researcher: and is there a reason you decided after your first with the hospital, to go with a different direction?

Participant: Yeah, so my first birth was not horrible, in that I mean it definitely could have been worse overall pretty good. My body fortunately works really well during labor, so everything went fine. I had very healthy pregnancies, but my doctor in the delivery room kind of panicked, which I later found out about wasn't an issue, and she had us pretty much, from the time we arrived, had us thinking our baby was going to die, and it turned out it was nothing. Nothing was wrong. Everything was totally fine, and eventually she apparently thought it was fine too, but never relayed that information to us, so my husband and I spent the entire 45 minutes of me pushing like a mad woman to get my baby out to try and save her life, not knowing that everything was actually ok when the doctor did know that. And it was ultimately kind of a realization that it was 12:00 at night, the week of Christmas, she came in in her sweatpants, I think she was just in a hurry to get home, and she knew I was a first time mom, and I wanted to push when I felt like I needed to push and do so at my own level of comfort, and that was going to take longer, than me pushing like a crazy person, thinking my baby was going to die. So that was the experience I had with my daughter. The whole labor was fine until that point and it was scary and traumatic. The nurse was very rude and didn't really take my birth

plan seriously. I think when my husband came in and told her the gist of it that we just didn't want any medical intervention if its not medically necessary, and we didn't want any medications, and she said good luck with that. That was before she checked me, and when she did she realized I wasn't kidding, I was going to have this baby without drugs, because I was already 7cm dilated when I got to the hospital.

Researcher: Where was this at?

Participant: That was in GA. Warner Robbins. And at that time we were on prime, because prime in that particular base meant we could chose our care provider still. When we got here we switched to standard, so why we did the switch, mostly because I wanted a more peaceful experience. I didn't, I wanted a provider that believed that birth was not an emergency, unless it was an emergency. I mean if it is then let's do something, but until then, I trust you and I trust your body and know that this is a normal process. And so that's when, we were actually stationed in Mississippi, and we actually chose to leave on our own early to get here on time to deliver at the birth center, because we were getting stationed here, and there were no out of hospital birth options in Mississippi at the time for us, where we were located.

Researcher: So you took off early to go to [the base] for the second one?

Participant: Just to have the second one here, yes.

Researcher: SO you said you were seeing the same mid-wife for the second one as the third one. Was she in [this city]?

Participant: Yes, she was in [the close civilian hospital].

Researcher: So, I am assuming, but I want to make sure; with the second two, you went, did you go in expecting a certain thing, and getting that out, like you knew you were going to have. Did you feel like you knew you were going to have a better experience?
Participant: Oh yeah! Even if it went, I mean, even if a medical emergency occurred, I felt like I could trust that it was truly an emergency, not just my provider being impatient. Which is kind of what happened the first time. And then I also felt like, worst case scenario, I end of having a C-section under general anesthesia to save the baby's life, or something like that, I knew this provider just, even in talking to her prenatally, was still going to do everything she could to try and make it the best experience possible for me. So that meant a lot to me, that I knew she was going to do what she could, and professionally I had worked with her before, so I had seen her in some really traumatic and difficult situations with clients, and I knew that she was honest when she said "I am going to do what I can to make this experience as enjoyable for you, given the circumstances, that I can" because she knew how important the birthing experience was to me, and how important the birth process is to a woman, not just in the room and physically, but in her life. And she truly believed that, so that was kind of the kicker for me, is that I knew she wasn't just talking about it, which is kind of what my first doctor did, she told me a lot of this stuff, but the truth behind it wasn't there. It was just to kind of placate me. And that was my first provider, and at the mention of a birth plan she kind of lost it, so the second provider was like, "I don't need a birth plan, you just kind of do birth", and she was like NO! You need a birth plan. It really it was a difference to me in the midwifery model of care and the medical model of care in how they see obstetrics in general. I mean with the midwifery model, its pretty much looking at the whole woman,

not just her physical state but her emotional state. So yeah, going from, I saw the value of being in the intricacies of the emotional state working together with the physical state of the body to bring a baby into the world, and that really is true. It is really a hormonal process, and your hormones are really in a lot of times in control and controlled by what you are feeling. So to have a provider that respected my feelings and wanted me to understand and be in control of the process was really important to me.

Researcher: Thinking back to the first one, if you had to rate it on a scale of 1-10, what would you give it?

Participant: Based on the birth itself [not the provider], I would give it a 7. Had the doctor not interfered and not, basically, lied to us it would have been a 10. It was a great. By far my most pain free delivery. The easiest baby for sure.

Researcher: If you had to go back and do the first one all over again, would you have done it the same way?

Participant: The first one, no I would not have, but at the time it was the right decision for us. Because we were not as trusting of the birth process and I think for a first child, for us, it was the right thing to be in the hospital, but knowing what I know now, no I wouldn't have.

Researcher: At the time, would you have recommended those services to family and friends?

Participant: At that time, before my delivery, I would have. After my delivery I would not have.

Researcher: For this one, on a scale of 1-10, what would you give it?

Participant: Oh an 10!!

Researcher: Would you recommend to family and friends using a mid-wife?

Participant: Yes, but let me caveat that with saying, if they want that kind of a birth. If I know I have a friend who is terrified of pain at all and the idea of giving birth without medication, in or out of a hospital, I would never recommend that for them. I absolutely would for a person that wanted a birth like the one that I had. It is not for everyone and yeah I definitely wouldn't recommend it for someone who wanted an epidural, or who was scared of birth. I think that that would be emotionally traumatizing. You have to believe in it. I think for some you have to work up to that and for others its just a working thorough it. For someone who desire a birth like I had, absolutely. I would say she is the best provider in the [local] area.

Participant A13

January 20, 2016

Demographics: Dependent, Air Force, Officer, 27YO, 0 previous deliveries, 41 weeks and 6 days, standard.

Researcher: So what was your reasoning for choosing standard, or where you always standard?

Participant: I chose standard when I got pregnant, because I wasn't satisfied with the way the base hospital did their division of obstetrics with the pink and the blue team and also I knew I wanted a little more independence and freedom and deciding my birthing plan, so I knew I wanted natural, midwife, the option to eat and move around and not be hooked up to a machine, so I pretty much had to go standard to do that.

Researcher: You mentioned a birth plan, so you had a birth plan going into this?

Participant: Yes, I did. It was a lose one.

Researcher: Did you get induced or you went into labor?

Participant: So the way that it worked, was that I was scheduled to be induced, however they tried a folly balloon first, and it worked, so I didn't have to have any chemicals, and they did that at the midwife center here and I gave birth at [the close civilian hospital] Medicine [formerly [the close civilian hospital] Medical Center]. So, technically on my chart at [the close civilian hospital], since I came in in labor, I wasn't induced, so yes and no.

Researcher: So, the midwife center, is that also a birthing center, or they just do...

Participant: It is a birthing center, and my plan was to actually give birth there, but because I was so far along, they had scheduled my induction for a Friday morning and I actually ended up doing the balloon the previous day and it started my contractions and dilations, so I ended up just going to [the close civilian hospital] med because they were already expecting me and it was in the middle of the night, so they ended up sending me there because they already had a room ready. But personally I would have preferred to do it at the midwife place.

Researcher: Thinking about your birth plan, what were some of the things that you were really were key on with those?

Participant: I didn't want any pain medication, no epidurals. I wanted to be able to kind of decide in the moment if I wanted to walk around, you know, so I wanted a little bit of freedom of movement. Like I mentioned the food; I wanted to be able to eat if I wanted to or drink. I also wanted as few interventions as possible. And that was pretty much everything that I had on the birth plan. It was very lose, I kind of wanted to decide in the

moment, I was not interested in any of the medical interventions unless it was a medical emergency situation.

Researcher: How well did you get to stick to that plan?

Participant: I did completely. The only unexpected thing was the folly balloon that they did. When they inserted that I was already a cm dilated, so that kind of kick started everything that was already happening, so outside of that everything else happened exactly the way I wanted it to.

Researcher: And so you would say your expectations for going in really met?

Participant: Yes

Researcher: You chose your midwife? And you got to see her throughout the entire process?

Participant: Yes, and she was also at the hospital throughout the whole time as well.

Researcher: Besides her being there, how was the hospital itself, as far as checking in, how were the doctors and nurses, did you have a lactation consultant that came by the help you, you can dive into all of those, but from start to finish, what aspects did you really like and what aspects did you not care for as much?

Participant: The facilities were great. I don't know if you have been to [the close civilian hospital], but its really new, the rooms are huge, so the facilities were excellent. I did prefer my night nurse to my day nurse, but they were both competent, it was just personal preference. I was really satisfied overall, the only really minor issue, and I think it is maybe just related to how I was presenting with pain and things like that, is I don't think they realized how far along I was, so when we went into the emergency room, they were very nonchalant and they had me stand up to do paperwork even though I probably wasn't

in a position to be moving around very much, and when my son was actually born, they didn't know that he was crowning, so everybody rushed in, and they were opening things, and it was a little bit of a surprise, I guess. But other than that it was fine, once they realized what was happening and that I was fairly far along they responded as appropriate.

Researcher: So then your midwife was there in the room but did a different doctor deliver?

Participant: No, she was the only one actually there in the room. It was me her and my husband, because they told me that whenever you are ready to push, just push, and the nurse had stepped out to go get me a birthing chair, but I ended up not using it because by the time she got back my son was already on his way out, and the midwife and my husband had caught him, and then everyone started rushing in with the lamps and the equipment, and all of that.

Researcher: So after he was born, how was the care from the staff and the nurses? Did you feel well taken care of, did they take him and let you sleep, or did you decide to keep him?

Participant: Yes, after he was born, they left all of those decisions pretty much up to me I was able to decide if I wanted to sleep. I had my mother-in-law there, so if I wanted her to be involved in the process, but I ended up choosing to keep him in the room with me the whole time and if I needed anyone to hold him my mother-in-law did that. They did offer, but I declined. And I didn't answer your earlier questions. I did have a breastfeeding consultant come in and coach me, and the nurses were very attentive and helpful, and doing their assessments, and helping me get around and get into the bathtub.

Researcher: And did you feel like they prepared you when you left. Were you ready? Did you feel like they helped you enough, that you were like, yeah I got this?

Participant: I think that they did. I was fairly hands off in all aspects. I did have to stay there 24 hours because he came out with meconium, so they just wanted to make sure they didn't aspirate any of that, so I was there for the full 24 hours, and while I was there they were very considerate in asking if I had any questions, if I needed anymore information, and they gave me a whole packet, or not just breastfeeding information, but support groups, and websites, and you know all kinds of different things, so yes I felt prepared.

Researcher: Did they call, like a week later to check on you?

Participant: They did call a week later, and I had my follow up appointment, and the midwife center too did separate calls and follow up appointments as well.

Researcher: Overall, if you had to rate your experience, you L&D, on a scale of 1-10, what would you rate it?

Participant: I would say it was probably a 9. Everything was really easy, really smooth; I didn't have any complications or troubles. I was greatly satisfied and it was about what was expected. I think really the only thing not giving it a 10 was my expectations, because I did want to and expected to be at the midwife center, and really the only thing I didn't prepare myself for was having to be induced and him not coming. I had prepared for a C-section, maybe if he came early, or complications like that, but it never crossed my mind that he just wouldn't come out. So that really is the only reason it wasn't a full 10, but that's all related to my own preferences, and not anything that anyone else did.

Researcher: Since you were not planning on delivering there, did you ever do a tour of [the close civilian hospital] Medical?

Participant: Part of being at the midwife center is you get to choose if you want the hospital or the center, and even if you do choose the center like I did, they do have you go and tour, in case something happens, like what happened with me and you have to unexpectedly be there.

Researcher: For the midwife center, would you recommend to friends and family?

Participant: Absolutely, they were wonderful. I still go there for my general well women's care

Researcher: For the hospital, would you recommend to family and friends?

Participant: Would you recommend the hospital for L&D?

Participant: Yes, I think I would, yeah!

Participant A14

Date unknown, 2016

Demographics: Dependent, Air Force, Enlisted, 34YO, 41 weeks at delivery, 1 previous pregnancy (but this is her first child), prime (pink) [Was just assigned to pink, said she didn't care which team she had]. [the close civilian hospital] medical center.

Researcher: We are going to focus on your birth experience here, not anything previous, but the labor and delivery part. Not the appointments or anything, but we can touch on that later. So, thinking back on labor and delivery, you can just tell me how it went, how did it start, what all happened.

Participant: I was at my 41 week appointment and they were doing the non-stress test, and they did it for like an hour, which they had told me was only going to be 20 minutes, but for some reason they just left me hooked up for a long time, and during that hour, his heart rate went down once, and so they aired on the side of caution and told me to go straight to the hospital to be admitted for delivery. I was already scheduled to be induced 4 days later, because they offered me, um, after I reached 40 weeks, because I hadn't been dilated or anything, and so they said you know probably, unless things change you are going to end up being induced, when would you like to do that; we will do that any time you want. I said why don't we wait till, um, I think it would have been 41 weeks and 3 days, because it was a Friday, and I was like let's do this on a Friday! SO I was supposed to be induced at 41 weeks 4 days, so at 41 weeks when he had that one dip they just sent me to the hospital, and so I drove myself over to the hospital and showed up and I went in and I thought it was interesting because when I got there the hospital staff were like, oh why did you come straight here, and I told them, well they sent me straight here, you know and I had never delivered a baby, so I was nervous, and they told me, oh you should have gone and gotten lunch, and got home and gotten your bag, and I said I asked them and they said no to come straight here. And they said well they kind of worked you up for nothing. But I get their reason, because they want to air on the side of caution and they don't want anything to go wrong. So, I went there and they started the actual induction and we did the "shoe string one", is that like cervidil? I would have to look it up. That goes in place. I did the one that was not the pill. I did not want to do that one. Because I liked the idea of the shoestring, that you could take it out if you needed to. Anyway, so I did that one and I was in bed for 12 hours while that did what it was doing,

and then the contractions started immediately pretty much as soon as they put that in, but after 12 hours I still hadn't really dilated at all, so they put Pitocin (2am), and they just kept bumping it up and bumping it up, and I think I got to about 4 cm and I finally after about 24 hours, I said lets have that epidural now, because I was in a lot of pain, and this isn't going anywhere, so I got the epidural, and then I felt great! And then my water broke on its own, and I was very relaxed, but his heart just started going down, just over and over, so they came in probably within 10 minutes of that starting to become a trend and they said you're still not dilating and he's still in stress, and we are going straight into C-section, and so literally they just started bundling everything up and wheeled me right into the operating room, and everyone was in there, because it is a training hospital, so they were lining the walls watching, and it was like a day when all the nursing students were there, so they were all in there, all the trainees. So, they were in there and they were getting me prepped, and I was very nervous because my husband was out in the waiting room and they seemed like they were really getting ready to start, and so I was kind of like "wait, wait, where is my husband". So then they sent someone out there to get him and they did the surgery. The baby was born and everything was great, and then when they were stitching me back up I thought it was funny, again, I know it is a training hospital, so I get it, but I kind of wish I couldn't hear because I heard the doctor telling the resident well be careful how you are stitching that right there, because no matter how pretty you make it on the inside, it's the outside that counts. I was just like, oh god, what is this going to look like!? But it was fine, and then we went back to our room with the baby. We were in recovery, and they were really nice, they let me stay three days. I guess usually its just two, but they asked me if I wanted to go home or what I wanted to do and

I asked if I could stay an extra day because I was really feeling poorly and they let me. That was really nice and I was really happy about that. You know when you are going to the doctors at [the base], it is just a rotation, you know you see whoever, so I saw every single doctor while I was at [the base], and it was kind of funny because I was joking with my husband because there was this one doctor that I didn't particularly care for, well there were two, but that I didn't care for very much, and one of them was new, she was a lieutenant, and the other one was a captain, and I just very, I don't think they meant to, but they kind of insulted me during one of my check-ups, and so they were just kind of talking down to me, because they were having a conversation about birth control and what I was going to do afterwards, and I was like my husband and I are going to use condoms, and they were like, you know we don't promote the use of condoms, its not a very good form of birth control. And I was like, lady, I'm 34 years old, like it took me a year to get pregnant with this child, I have my college degree, I work for the government myself, like I'm not some 18 year old kid who doesn't know what they are doing; I understand where babies come from, but they just kept harping on it, and the one doctor brought in the doctor who ended up delivering, and both of them were just coming at me about it, and I was like I understand how birth control works and they were like, well I guess we will just see you here sooner, rather than later I guess after you have your baby. I was so angry. I told my husband, like, what is going on. I am not a child. I thought maybe it was because we were enlisted? Do they just see this kind of problem a lot and they are just assuming things? I didn't understand where it was coming from, so anyway, one of those doctors ended up delivering, and I was like, oh great it's her, but the funny thing is she didn't remember me at all because you know they see so many patients, and I

was like I remember you because that was just two weeks ago, but she doesn't remember. So that was just kind of a funny aside, and it is something that I think happens in the military care system because you do see so many different doctors, and it is kind of whoever happens to be on duty at that moment [with the delivery]. Which, I mean, some women kind of wanted to have more of a personal relationship. For me I didn't care. It was whoever was going to get this child out of me, is really all I cared about.

Researcher: Looking back before you delivered, what were your expectations? Did you do a tour of the hospital?

Participant: Yeah, I did. My husband and I took the tour of the hospital, since this was our first, and I mean we were both the oldest ones in that class, and my husband's older than I am. He is 38, so I mean we found it informative, it was nice to go on the tour. I was reassuring. We don't have any family here and we had just, we hadn't even been here a year when we got here, so it was nice to go to the hospital to see what it was going to be like and get our questions answered and that sort of thing.

Researcher: Did you have any other expectations going into it?

Participant: I don't think I had any expectations at all. I had no idea what was going to happen. So it worked out well. I mean I was hoping to be able to deliver vaginally, and that didn't happen, and that's ok.

Researcher: Would you say, because you really had no expectations going into it, that everything?

Participant: Well we had never done it before, so, our only goal was to have a baby.

Researcher: Everything kind of just happened, and it just happened?

Participant: It did, yeah we had our baby and then it was I mean I had a C-section so I had a lot of pain after, and I was, so then the hospital staff was like you need to take these pain medications because you are going to be in a lot of pain and I kept telling them no, I said what are you giving me, and it was Percocet or something like that, and I said no I had surgery in the past and I always have a bad reaction to this, like I get very, very nauseous, and they were like, no, no this will not, and I was like yes, really it will. They just kind of insisted, so they ended up giving it to me, and then ya know they were like let's sit you up, and as soon as I sat up I just lost my entire lunch right there, and I was so annoyed because I was like, i told you guys this and you didn't listen, but that's every hospital, it isn't them specific. That is medical staff in general, because they want you to be comfortable and they need you to be mobile, but I think they also need to listen to their patients. I know they prolly see a lot of patients who are probably like you know kind of scared of everything that they are doing and just kind of push back on everything, but I was trying to tell them, no I really do have a reason. After that happened, they were like, oh I guess you were right. You know, but I didn't fight them. I think I did get up and walked around. There were really, I just felt like the staff was really lovely, and everyone was so nice and kind and helpful, and they took the baby in the middle of the night for like an hour just to let us have a little bit of sleep, just really great. It is nice because it can be a little overwhelming. They were really helpful and wonderful.

Researcher: So overall, on a scale of 1-10 what would you rate the hospital?

Participant: The hospital, like the facilities, and staff?

Researcher: Let me rephrase. What would you rate your labor and delivery experience within the hospital.

Participant: I mean I don't have anything to compare it to. I guess I would, I mean, having no expectations going in, I would probably put it at like a 9. I thought it was great.

Researcher: There is no wrong answer.

Participant: No I get that, I was actually thinking about it before you called. I was thinking to myself, I don't really have anything to compare this to, but I guess in general how I felt about it, I felt really great. I mean, nothing is perfect, but it was pretty darn good.

Researcher: This is the last thing I will touch on, but thinking about the pre-birth, like all of the doctors appointments and all of the rotations. Other than the two that were kind of being pushy about the birth control, were there any other issues, or anything that you were like, wow this is great?

Participant: I really liked the, I don't know, I felt like everyone was really nice. And it was great that I hardly ever waited when I went to my appointments. Like they would get me in right away, which I appreciated, and especially now that I have a child and I take him over to the pediatrician and they are terrible about waits. I think that is even worse when you have a small child and then you are waiting for like 30 minutes to get to your appointment, so I really liked that on the pregnancy/OB side you are in and out. I liked that. ***You know sometimes I felt like I would ask questions, and maybe I was just asking dumb, first-time mom questions, but I felt like I never really got answers to some. Like, about my weight gain. I didn't gain any weight until the very, very end, and then suddenly I put on 20 pounds in like a month and I was like really upset about this and I was telling them oh my god this is a problem, and they were like "don't worry about it". You know it's nothing [big], but that is the only response I got, no you're fine. I***

don't know, I guess I just wanted to talk about it more or something, but I know that they have a lot of patients to see and just like any other doctor, they are not just going to spend 30 minutes with every person that comes in there. So I don't think it is really a complaint against them, just maybe doctors in general. I know they are very busy. I wanted to talk, but no I thought it was great. Yeah, aside from those doctors, that maybe just kind of, you know, the thing about the rotation is that they never really get to know you, so I think that is where some of those responses would come from, because they don't really know anything about their lives or where they come from, I think I must have described the back that I had been pregnant before, ya know probably like 10 times during my pregnancy because every time I would see someone new, or someone that was on a training rotation, who wasn't even normally there but they were just there for a couple weeks, and so I would always be like, yeah I was pregnant before and this happened, and this happened, and this happened, and so you know it gets, I think it was actually the bulk of my appointments, just telling the same story over and over. ***But again, I mean, it is a free service, bottom line, I am not going to complain.*** If I was paying $100 an appointment, maybe I would be annoyed, but you know I can't complain about it especially for what it is. It was great, just a great experience, and I would gladly do it again. I wouldn't change to standard. I would stick with prime. I would stay with going to team pink or team blue, whoever they give me. Because I thought that all the doctors were very knowledgeable and very good, and obviously you are going to personally click with some more than with others but all of them, I felt were competent. They all knew what they were doing.