

Caring for the Whole Woman: A Program for Practitioners of Obstetrics and Gynecology

Erika L. Yamin

A Dissertation Submitted to the Faculty of  
The Chicago School of Professional Psychology  
In Partial Fulfillment of the Requirements  
For the Degree of Doctor of Psychology

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2017

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## Abstract

Based upon original research, existing literature, related medical curricula, and public health records, this project discusses the need for and benefits of a specialized psychoeducational program for practitioners of Obstetrics/Gynecology. This program, Caring for the Whole Woman, expands upon medical definitions of women's reproductive experiences, examines the social, psychological, emotional, spiritual, and cultural aspects of these experiences, and describes how these aspects may present within the medical model. Program participants will learn patient-centered communication skills and how to effectively identify and refer patients in need of support. Moreover, participants will explore their experiences of working in women's health, process their reactions to their work, connect with their core values as healers, and learn strategies for coping with, and ultimately utilize their own emotions during interactions with patients. Physicians specializing in Obstetrics/Gynecology completed surveys designed to explore the extent to which physicians' experiences during medical school and residency prepared them to encounter and engage non-biologic aspects of reproductive health. Of particular interest for program development was if doctors feel well-prepared to effectively interact with patients about non-explicit medical aspects of care, whether they are interested in learning more about these issues, and if so, what specifically they would like to learn. Survey data is also analyzed in the context of a thorough literature review outlining current issues in obstetric training and practice, the maternal healthcare system, and women's experiences and preferences regarding their healthcare.

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## Chapter 1: Introduction

Research that explored the experiences of obstetricians and gynecologists (OB-GYNs) during their training and practice found that a significant cause of stress for these physicians is the practical and emotional dissonance they experience when their objective, science-based medical training and culture meets their patients' need for care that is empathic, emotionally-attentive, and patient-centered (Burack et al., 1999; Chalmers & McIntyre, 1993; Feldman-Winter et al., 2010; Fields et al., 2011; Fraser et al., 2000; Ghetti et al., 2009; Goldenberg et al., 2013; Hojat et al., 2004; Hojat et al., 2009; Huntington & Kuhn, 2003; Jani et al., 2012; Jiménez & Thorkelson, 2012; Knight, 2011; Konner, 1987; Neumann et al., 2009; Novack et al., 1997; Pereira & Holanda, 2013; Rosenfield & Jones, 2004; Scheffer, 2011; Shapiro, 2008; Sheehan et al., 1990). These findings are confirmed by physician accounts of feeling ineffective and/or uncomfortable when encountering certain patient interactions and medical scenarios. Moreover, the medical field is experiencing increases in malpractice suits and corresponding insurance costs, increases physicians' perception that they must practice "defensive medicine," and a decrease in patient satisfaction and compliance, all of which degrade the patient-physician relationship.

The current lack of attention to psycho-social-emotional-spiritual aspects of wellness and pathology in medical training represents a Cartesian understanding of the separation between mind and body. More modern evidence demonstrates that emotional and psychological states directly impact physical states, and that compassionate care and a strong patient-physician relationship leads to better patient outcomes (Knight, 2011). Medical training has failed to adapt to today's market conditions as well as the most current evidence on best care practices. This has created a gap between the type of care that patients desire and need, and the care that

physicians are trained to provide. This situation is reflected by current U.S. trends of increased interest and utilization of alternative healthcare of all types.

Regarding women's reproductive health specifically, American women are increasingly seeking care from midwives instead of physicians and choosing to birth at home or at birthing centers instead of at hospitals (Declercq et al., 2007; Epstein et al., 2008; MacDorman et al., 2014; Rosenthal, 2013). This trend reflects an increased awareness about the U.S.'s poor maternal health outcomes, in terms of high rates of chemical and surgical interventions, high maternal mortality, and high infant mortality, as compared with maternal health outcomes in other industrialized nations across the world. Moreover, the diagnose-and-treat medical mode, which pathologizes normal female reproductive functions such as menstruation, pregnancy, childbirth, and menopause, has long been criticized for its impact on women's agency, autonomy, and self-trust in reproductive contexts (Adams, 1994; Beck, 2004; Brujin, 2008; Creedy et al., 2000; Davis-Floyd, 2003; Ehrenreich & English, 1973; Fisher et al., 1997; Fraser et al., 2000; Griebenow, 2006; Jordan, 1993; Kendall-Tackett, 2007; Koo et al., 2003; Rich, 1976; Soderquist & Wijma, 2002; Wagner, 2006). This perspective highlights patient accounts of being disempowered, shamed, patronized, misinformed, and even abused during their receipt of care. Yet, few widely-applicable and pragmatic solutions or alternatives have been proposed. Instead, debates over the proper care for maternal processes are habitually reduced to acrimony between proponents of "medical" vs. "natural" birth.

By amending OB-GYN training so that providers understand childbirth not only as a medical event, but also as a social, emotional, and psychological life transition, practitioners may feel more competent as caregivers and their patients may have a higher quality experience. Such an initiative is likely to appeal to physicians incentivized to avoid lawsuits, improve patient

outcomes and satisfaction, increase word-of-mouth referrals, and gain confidence and satisfaction from a broader mastery of their craft. Systemically, the provision of advanced didactics regarding the non-explicitly medical aspects of women's reproduction and how to handle them in a medical setting hold the potential that such provider-level intervention will reduce costs and improve outcomes.

For such an intervention to be helpful, it must be sensitive to and accepting of medical culture and will need to model humanistic and relational values in its delivery. Additionally, it must provide information that is relevant for physicians in that issues emphasized in training relate to situations that doctors encounter in practice, yet do not create an unreasonable conflict between doctors and the systems in which they work. To accomplish both these goals, residents and practitioners in obstetrics and gynecology must be consulted about their needs and wants in regard to training, and their input must be a cornerstone of the design for the training program. In the long-term, the program should be assessed for quality of both performance (do doctors feel that the program is helpful) and outcome (does implementation of the program result in increases in patient satisfaction with their care).

## Chapter 2: Literature Review

### **Background**

More than four million babies are born annually in the United States, with only an estimated 28,000 born outside of hospitals (CDC, 2008). Overwhelmingly, the vast majority of American women experience this life event at the hospital, under the care of practitioners operating within the medical model. A near-universal experience of medicalized childbirth is not only unique to American women, as compared with modern women in comparable countries (Davis-Floyd, 1992; Jordan, 1993; Wagner, 2006), but is unique to the last century of American life. Although the ubiquity of this type of care is highly temporally and geographically specific, the medical model is hegemonic in practice. Historically, midwives acted as counselors, abortionists, healers, pharmacists, and nurses (Ehrenreich & English, 1973). Their primary goal as experts on the process of childbirth was to ensure a safe delivery and minimize the mother's suffering. Since there was only one midwife for a whole village, she served a vital role for her community.

The American Industrial Revolution marked a cultural rise in the valuation of technical and scientific knowledge, especially as an idealized form of control over nature. Samuel Slipp (1993) explained, "Men's reliance on science and rationality now fueled a renewed effort to master the environment" (p. 46). As a result, those possessing scientific knowledge and abilities were naturally positioned to become the most legitimate and prestigious social authorities. The first medical school was founded in Pennsylvania in 1765, and the first licensure laws calling for formalized examinations of prospective doctors followed soon after. The word *obstetrician*, formed from the Latin "to stand before," was first used in 1828. The American Medical Association (AMA) was founded in 1848 and the founding of the American College of

Obstetrics and Gynecology (ACOG) followed in 1888. As the institutionalization of the medical model grew, the hospital system of medical care was soundly entrenched in American society by the early-to-mid 1800s.

While midwives traditionally relied heavily on herbal medicines and treatments, physicians espoused the dominant medical belief of the time, humorism—the idea that the body was comprised of four humors that caused sickness when unbalanced. Accepted practices based on this theory included blood-letting, leeching, and purging. In contrast to this supposedly scientific approach, the midwife’s herbal and experience-based approach was perceived as crude. As the amount of money to be made in the field of obstetrics mushroomed, due to the well-to-do’s high demand for new technologies, “the few physicians who were known to be qualified...promptly limited their practice to obstetrics” (Rich, 1986, p. 233). This new market was soon to be monopolized by men with formalized medical training, and as Carol Karlesen (1988) described in *Devil in the Shape of a Woman*, “The frequency with which doctors were involved in witchcraft cases suggests that one of the unspoken (and probably unacknowledged) functions of New England witchcraft was to discredit women’s medical knowledge in favor of their male competitors” (p. 143).

The medical model, drawn from the Cartesian notion of the *machina animata*<sup>1</sup>, provided a philosophical basis for the Scientific and Industrial Revolution. This theory posited that mind and body were entirely separate, the body operating entirely independently from the mind. The new healthcare system did not metaphorize human bodies as equal in their mechanicity (Davis-

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<sup>1</sup> I should like you to consider that these functions (including passion, memory, and imagination) follow from the mere arrangement of the machine’s organs every bit as naturally as the movements of a clock or other automaton follow from the arrangement of its counter-weights and wheels. (Descartes, *Treatise on Man*, p.108, 1629)

Floyd, 2003). The male body was established as the prototype of the machine, whereas the female body was considered inherently defective. This distinction may be understood as couched in a historical view of women as lesser-than, but also as the result of a female anatomy that keeps the body's inner workings frustratingly obscured and mysterious, and to irregular and unpredictable reproductive functions of menstruation, conception, pregnancy, birth, lactation, menopause. Moreover, pregnant and birthing bodies operate to disrupt some of our culture's most basic scientific groundings: that one individual exists per body, that one does not equal two, and that a clear distinction exists between inner and outer (Davis-Floyd, 2003). These and other "objective" dualities constitute the frameworks for the scientific categorical understandings of the world; the maternal body, then, personifies a disruption of social order and must therefore be highly monitored and managed. To the extent that technology is idealized as a means for control over nature, its perceived ability to manipulate unpredictable and ambiguous forces—thereby rendering them less threatening—became, and remains, crucial to a collective sense of safety.

A psychoanalytic approach to this dramatic change in the conceptualization and delivery of women's healthcare recognizes the role of fear and envy of the creative reproductive potential of female sexuality. From this perspective, the medical model of maternal care transforms the female body's creative function into a demonstration of scientific, technological creativity, transferring the natural to the realm of cultural technology and thereby restoring human control. Alice Adams (1993) elaborated on this by theorizing that in the dominant technologically-driven birth model, childbirth is seen as an escape from the womb, which becomes an allegory for scientific and philosophical enlightenment.

When conceptualized as abnormalities, women's reproductive processes were seen as an inherently dangerous and unpredictable processes in need of abstract scientific knowledge and

technological intervention. In this way, a series of normal biological processes was formatted to fit the medical model, and the medical profession effectively redefined appropriate maternal care. In 1910, about 50% of all babies were still delivered by midwives, primarily in black and working-class areas, and by 1939, 50% of all women and 75% of urban women delivered in hospitals (Ehrenreich & English, 1973). In 1960, 97% of babies were born in hospitals (Feldhusen, 2000). As opposed to the traditional midwife, the doctor was “a technician rather than a counselor, guide, and source of morale; he worked ‘on’ rather than ‘with’ the mother” (Rich, 1986, p. 136).

The feminist health movement of the 1970s spurred a resurgence of home birth, care from midwives or “non-experts,” a radical assertion that female reproductive experiences were normal rather than pathological, and a demand for empowering, informed, patient-centered care. Seemingly, a long-term outgrowth of this movement, the 2000s have marked a shift in how Americans in general view themselves as consumers of healthcare services (Gilbert et al., 2013; Knight, 2011; Pearlman & Gluck, 2005; Reddy, 2014). Literature and documentaries released in recent years give a voice to a cohort of individuals who have expectations for their care that are a poor fit with current mainstream options (Beck, 2004; Brujn, 2008; Cheng et al., 2014; Creedy et al., 2000; Deqlercq et al., 2007; Epstein & Lake, 2008; Jarmel, 2000; Moore, 2016). These women actively seek care that is humanistic, evidence-based, and individualized, and are likely to do their own research and question their doctor’s recommendations. Although still relatively rare, out-of-hospital births account for a growing share of U.S. births since 2004, with the 2012 rate the highest the country has seen since 1975 (MacDorman, Mathews, & Declercq, 2014). In 2012, six states had 3%-6% of their births occur outside of a hospital; for an additional five states, 2% and 3% were out-of-hospital births. Variations in the percentages of these births by



state are likely influenced by differences in state laws pertaining to midwifery care, as well as by the availability of birth centers. Across the country, the rate of planned home births increased by 36% (from 0.8% of all births in 2004 to 1.09% in 2009) among non-Hispanic white women.

This trend may be understood to represent an attitudinal shift, as individuals begin to see themselves as active and informed consumers of their healthcare.

### **Approaches to Maternal Healthcare**

Every obstetrician and midwife undoubtedly practices their own unique form of care, but Davis-Floyd (2003) provided a clear breakdown of the general differences between a medical and a natural approach. Her comparative chart is soundly researched, based on literature from both the medical and midwifery communities, and on her own interviews with birthing women, midwives, and obstetricians.

Table 1

Adaptation of Davis-Floyd's Birth Model Comparison

<b>The Medical Model of Birth</b>	<b>The Natural Model of Birth</b>
Woman = object	Woman = subject
Body = machine	Body = organism
Mind is separate from body	Mind and body are one
Female reproductive body = defective machine	Female reproductive body = healthy organism
Pregnancy and birth inherently pathological	Pregnancy and birth inherently healthy
Doctor = technician	Midwife = nurturer
Baby is separate from mother	Mother/baby = inseparable unit
Baby grows itself through mechanical process	Intimate connection between growth of baby and state of mother
Safety of fetus may be pitted against emotional needs of mother	Safety and emotional needs of mother and baby are the same; good for mother = good for baby
Supremacy of technology	Sufficiency of nature
Importance of science/things	Importance of people
Action is based on facts, measurements	Action is based on body knowledge, intuition

Technical knowledge is emphasized	Experiential and emotional knowledge valued as highly as or more than technical knowledge
Appropriate care is objective, scientific	Best care stresses subjective empathy, caring
Health of baby during pregnancy ensured through drugs, tests, techniques	Health of baby ensured through physical and emotional health of mother, attunement to baby
Labor = a mechanical process	Labor = a flow of experience
Uterus = an involuntary muscle	Uterus = responsive part of whole
Time is important; adherence to time charts during labor is essential for safety	Time is irrelevant; the flow of a woman's experience is important
Birth must happen within a given timeframe	Labor can be short or can take several days
Once labor begins, it should progress steadily; if it doesn't intervention is necessary	Labor can stop and start, follow its own rhythms of speeding up and slowing down
Medical intervention necessary in all births	Facilitation (proper food, effective positioning, support) is appropriate, medical intervention usually inappropriate
Environmental ambience is irrelevant	Environmental ambience is key
Woman in bed hooked up to machines with frequent exams by staff is appropriate	Woman following her instincts—moving, being with her partner, eating, sleeping, listening to music—is appropriate
Labor pain is problematic, unacceptable	Labor pain is acceptable, normal
Analgesia and anesthesia for pain	Mind/body integration, labor support for pain
Iatrogenic pain is acceptable	Practitioner must strive to cause no pain
Birth = a service medicine owns and supplies to society	Birth = an activity a woman does that brings new life
Obstetrician = supervisor, manager, technician	Midwife = counselor, advocate, guide
The doctor controls	The midwife facilitates
Responsibility is the doctor's	Responsibility is the mother's
The doctor delivers the baby	The mother delivers the baby

The most foundational difference between these two ideologies is whether the birth process itself is seen as trustworthy and/or normal. As such, the fundamental theoretical disagreement lies in whether or not danger is perceived as inherent to female reproductive bodies and functions. The natural model of birth posits that for healthy women receiving prenatal care, birth is usually safe, and is made *less* safe when emotionally or physically uncomfortable interventions are performed. According to the medical model, female reproductive processes are made safe through scientific, technological, and medical intervention. In one view, nature is

revered as the most appropriate authority in the birthing process; in the other, science is revered, and nature viewed as a threatening force that must be tamed.

### **Obstetric Training**

With an understanding of the medical model of care and the structure of medical training, it is axiomatic that obstetricians, both historically and presently, do not operate from a counselor-caregiver model. However, to the extent that pregnancy and childbirth are not only biological functions but also meaningful personal and social events that do most often proceed normally (without pathology), they can be a relatively awkward fit within the diagnose-and-treat medical model. How does medical training equip students to cope with all the needs of maternity patients, and how may this training serve to subvert the authentic instincts and motivations many obstetricians possess before beginning formal training? An anthropological perspective that conceptualizes long-term training as a rite of passage and qualitative research describing the experiences of medical students, aid in illuminating how the process of becoming an obstetrician shapes the way a physician will ultimately practice. The following analysis is particularly concerned with the short and long-term psychological impact of medical training on physicians.

In a quest to explore how medical training prepares physicians to treat pregnancy and childbirth, medical anthropologist Robbie Davis-Floyd (2003) conducted in-depth interviews with twelve obstetricians during the winter and spring of 1987. While her sample is small and her study arguably outdated,<sup>2</sup> her analysis of the unspoken culture of medical school remains

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<sup>2</sup> In the preface to *Birth as an American Rite of Passage* (first published in 1992), Davis-Floyd wrote, “Various individuals, including students, have questioned the contemporary relevance of the theories and data in *Birth as An American Rite of Passage*. I have to say, in all honesty, that twelve years after its publication, this book is as relevant as it was when it first came out. The contemporary situation is simply an intensification of the situation I describe in these pages” (xii, 2003).

relevant in revealing the psychological impact of the culture of institutionalized medicine on individual caregivers. Davis-Floyd (2003) explained:

Although I do not question the existence of profound differences between physicians, my analysis...concentrates on what I have come to see as a hidden 'core curriculum' that is taught in medical schools in myriad ways and perpetuated by example in residency training. Basic aspects of this core curriculum include the practitioner's systematic objectification and mechanization of, and alienation from, the patient. (p. 253)

Davis-Floyd understood this curriculum as divided into two primary phases: hazing and habituation. The first two years of medical school constitute a hazing<sup>3</sup> component of the rite of passage of becoming a physician. During these years, the core focus of education is hard science that is largely divorced from explanations of practical relevance and is taught by rote memorization. The sheer quantity of the material to be memorized creates in the trainee a state of extreme stress, physical and mental exhaustion, and increasing social alienation. Medical students may ultimately develop a sort of tunnel vision, whereby they are able to focus only on what is immediately before them, become progressively less capable of reflexivity, and lose touch with the ideals they had upon entering school. Davis-Floyd (2003) observed that "two years of nothing but science, besides serving to separate the nascent physician from the person he once was, also serve very effectively to separate him from the people whom he will treat" (p. 256). This view is echoed by Marsden Wagner (2006), obstetrician and former Director of Women's and Children's Health at the World Health Organization, who described how during medical school he and his peers became "more and more removed from normal life" (p. 17). His

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<sup>3</sup> With "hazing" defined as practices that seek to abuse and/or humiliate newcomers as part of their initiation into an exclusive organization and that organization's values, norms, and rules.

analysis of his own medical training illustrates Davis-Floyd's point that formalized learning is not only the source of technical knowledge, but of social lessons as well.

An abundance of research demonstrates that medical students experience a profound degradation of their empathic skills throughout the course of medical training (Burack et al., 1999; Fields et al., 2011; Field & Haslam, 2008; Ghetti et al., 2009; Hanson & Callahan, 1999; Hassed, 2004; Hojat et al., 2009; Hojat et al., 2004; Jiménez & Thorkelson, 2012; Konner, 1987; Moyer et al., 2010; Scheffer, 2011; Shapiro, 2008). A specific source of distress for students lies in both the "hidden" and "formal" curricula of medical school which dictate not only what to know, but also what to feel (Jani, Blaine, & Mercer, 2011). The emotional trajectory of medical students is something of a "gradual transformation" whereby medical students enter school "eager and enthusiastic" but slowly become "cynical, frightened, depressed, and filled with frustration" (Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990, p. 533). For many medical students, it is not only the process of engaging long-term in the rote memorization of abstract materials in a competitive environment that leads to early emotional burnout; cynical attitudes toward patients and exclusive prizing of diagnostic information over subjective, intuitive information is also modeled and enforced by professor-physicians. In a study of medical student abuses, one third-year medical school class was surveyed in order to explore student experiences of mistreatment and professional misconduct in medical school training as demonstrated in the following table.

Table 2

Representation of Findings from Sheehan et al. (1990)

<b>Incident(s) Reported</b>	<b>Percentile Reporting "Yes"</b>	<b>Additional Notes</b>
Yelled or shouted at Subjected to humiliation or belittlement Subjected to inappropriately nasty, rude, or hostile behaviors	85%	73% reported being cursed at
Threatened with physical harm	24%	
Slapped, kicked, hit, and/or had things thrown at them	16%	One student reported being kicked "in the testicular region" by an attending physician and needing medical attention for his injury
Required to place patients at unnecessary medical risk	44%	
Sexually harassed	55% (of female respondents)	29% felt they were denied opportunities in their training because they were women
Experienced ethnic or racial slurs	50% (of non-white respondents)	
Experienced sleep deprivation	85%	Reported most frequently on surgery clinical rotations, followed closely by obstetrics and gynecology
Observed residents or interns cover up mistreatment of patients	40%	20% witnessed clinical faculty cover up mistreatment of patients

In addition to clear concerns for the well-being of these students, this study raises important questions regarding the quality of patient care. For trainees, enduring mistreatment for long-term periods of time, within the closed society of the medical school community, has significant clinical implications. Of the 85% of students who reported experiencing sleep deprivation, 97% also reported that this deprivation impaired their ability to care for their patients. A majority, 75%, of respondents reported becoming more cynical about the medical

profession as a result of the episodes elicited by the researchers' survey, and 25% reported they would have chosen a different profession had they known the extent of the mistreatment they would endure. A majority of respondents, 63%, reported that the mistreatment they suffered had a negative effect on their emotional health and, for 24%, this effect was reported as "marked" or "extreme." Sheehan et al. (1990) found that medical students may experience long and short-term "emotional health problems, declining humanitarianism, dishonesty, greed, cynicism, and a lack of independent thinking" (p. 537).

The "habituation" component of medical training "serves to impute permanence and legitimacy to what are actually evanescent cultural constructs" (Moore & Myerhoff, 1977, p. 8). In addition to the sense of inevitability experienced by low-level inductees of a closed group of powerful individuals, the routine standardization of many medical procedures creates an appearance of science and of medicine's infallibility and inflexibility. For students of obstetrics, the most salient routines are ultimately limited to those relating to childbirth. Standard procedures for a "normal birth" include but are not limited to place the laboring woman in a wheelchair, remove her normal clothing, perform a vaginal exam, administer an enema, shave her pubic hair, place her in the lithotomy<sup>4</sup> position, limit or prohibit her access to food, place an intravenous needle into her hand or arm, offer or administer analgesia, offer or administer Pitocin<sup>5</sup>, attach an external fetal monitor to the woman by means of a large belt strapped around her waist, perform vaginal exams at least once every two hours, offer or administer an epidural, transfer her to the delivery room, drape her with sterile sheets, douse her genitals with antiseptic,

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<sup>4</sup> Lying on the back

<sup>5</sup> An artificial hormone that can initiate and strengthen labor

and perform an episiotomy<sup>6</sup> (Davis-Floyd, 2003, p. 73-74). These procedures may occur during the period when the patient enters the hospital to the moment of her delivery; a whole other set of standardized procedures apply after her baby is born. For Davis-Floyd, “such ordered, acted, and stylized techniques serve to deflect questioning of the efficacy of the underlying beliefs and forestall the presentation of alternative points of view...these routine procedures ensure that the more nascent obstetricians see birth managed this way, and the more they themselves actively manage birth this way, the stronger becomes their belief that birth *must* be managed this way” (Davis-Floyd, 2003, p. 259). Furthermore, Davis-Floyd argued that these routines come to be meaningful for caregivers as mechanisms for ensuring the certainty of their outcomes. Therefore, any change in standard procedures is viewed as an equivalent reduction in certainty. This reasoning can help explain reluctance to alter or customize routines, for physicians “are taught to regard these procedures as the direct cause of the general success of the birth process in modern times” (Davis-Floyd, 2003, p. 260). Moreover,

The power of the habituating process seems to ensure that failures generally will be attributed not to flaws in the rituals themselves, but to the inherent defectiveness of nature and the female body. Thus each significant failure experienced...will lead to

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<sup>6</sup> A surgical cutting of the vagina and/or perineum to widen the opening



intensified performance of the rituals designed to prevent such failure, rather than to their rejection (Davis-Floyd, 2003, p. 262).

Although the logic described is tautological, it makes sense if one accepts the premise that technology always improves things by making them more controlled and predictable.

As such, the medical model effectively functions to obscure the reality that, despite the sophistication and ubiquity of scientific and technological advances, human beings are sometimes not in control of what happens with our bodies. Davis-Floyd concluded,

Obstetrical residents who have experienced the agony and confusion of maternal or fetal death or the miracle of a healthy baby when all indications were to the contrary know at some level that ultimate power over birth is beyond them and may well fear that knowledge (Davis-Floyd, 2003, p. 257).

It is important to recognize the relationship between the hazing and habituating of medical students and the medical model's myth of near-total control over nature. Brutal as the transmission may seem, practicing physicians may simply be giving initiates the skills they need to cope with the psychological work of maintaining the medical model's narrative when faced with the material reality of clinical work.

### **Psycho-socio-emotional Impact on Physicians**

If the theory of medicine demands objectivity, so does its practice, as a person working very long hours on the front lines of human suffering and death must require some emotional armor. Interestingly, first year medical students show a solid understanding of patients' emotional experiences, although they have little knowledge of biological illnesses; conversely, fourth year medical students demonstrate mastery of diagnostic information related to biological illness but are lacking in understanding about patients' emotions (Rosenfeld & Jones, 2004). As

trainees, medical students face a denial that doctors have feelings, and this matter-of-fact matter-of-factness may actually contribute to students' sense of vulnerability and lack of mastery as they face their own struggles. In trying to cope with anxiety about both the content (suffering/death) and process (feeling like an inadequate doctor) of interactions with patients, students develop coping mechanisms that translate to a decrease in their level of empathy for their patients. This transformation is likened to "battered child syndrome" and attributed it to an emphasis on emotional detachment and affective distance, clinical neutrality, and a lack of role models demonstrating any alternative (Hojat et al., 2004). In one study of medical residency programs, attending teacher-doctors on inpatient medical teams habitually showed disrespect for patients, avoided patients deemed to be difficult, and sometimes demonstrated outright hostility or rudeness during patient interactions (Burack, Irby, Carline, Root, & Larson, 1999). When doctors did directly address the doctor-patient relationship, the ideal of detached concern—that a doctor should try to remain objective or detached from the patient, but benevolently concerned about his or her welfare—was reinforced. Ultimately, the gradual process of unlearning empathy may be understood as a "learned dehumanization of self and patient and a traumatic de-idealization" of the physician's role and of the patient's needs (Hojat et al., 2004, p. 38).

In a paper evaluating the psychological challenges involved in obstetric practice, authors concluded that a "failure to understand the psychological aspects of patients' presentation leave the doctor feeling vulnerable and inadequate, searching for the right thing to say, and avoiding that patient in the future" (Cockburn & Pawson, 2007, p. 35). Interestingly, often, values like idealism, enthusiasm, and a dedication to serving humanity are in fact present in students at the onset of medical school (Neumann et al., 2011). Possession of these traits, however, can be a disadvantage for initiates working to adapt to the medical culture, and for this reason, such traits

“diminish as trainees are confronted with clinical reality and their focus shifts to technology and objectivity rather than the humanistic aspects of medicine” (Neumann et al., 2011, p. 999).

Nearly all the studies in this review evidence a profound decline in medical students’ empathy over the course of their training, and posit that “Encountering morbidity and mortality heightens trainees’ feelings of vulnerability...these feelings are often guided by the unrealistic expectations that medicine can always cure and there is always a ‘right thing’ to do” (Neumann et al., 2011, p. 999). To cope with fear and anxiety in the face of patient suffering and death, physicians may detach emotionally and focus their attention on what is controllable and knowable; in other words, students and doctors alike prefer to “...concentrate on molecules, organs, reports, and data rather than on the patient” (Neumann et al., 2011, p. 999). Moreover, medical students defensively ignore both patients’ distress and their own feelings not only in order to escape a sense of helplessness but also out of an active desire to remain detached and objective (Rosenfeld & Jones, 2004). This desire appears to be in itself an aspect of a students’ performance anxiety about practicing medicine the right way.

Due to the imperative that the process of caregiving and the way a doctor feels about that care remain tightly controlled, the element that introduces nearly every potentially problematic variable—the patient—becomes the antagonist to a physician’s perception of success. Thus, a troubling dynamic of physician-versus-patient instead of physician-with-patient can become the norm. Melvin Konner (1987), an anthropologist who completed medical school and documented his experiences, wrote:

It is obvious...that the stress of clinical training alienates the doctor from the patient, that in a real sense the patient becomes the enemy (*Goddammit, did she blow her IV again? Jesus Christ, did he spike a temp?*). Not only stress and sleeplessness, but a sense of the

patient as the cause of one's distress contributes to the doctor's detachment. (Konner, 1987, p. 267)

How and why this occurs can be understood if one considers that:

A sequence of close identification with patients in the early years of medical training followed by a flooding of that identification due to the intense, traumatic emotional experience of feeling so much like the desperately ill patients or even the cadaver... It results in a series of counter-identifications against patient experience and in favor of identifications with faculty. (Rosenfeld & Jones, 2004, p. 192)

In other words, an initial problem of excessive identification with patients may be solved through an adoption of under-identification where sharing the radical vulnerability of the patient is rejected in favor of adopting the power, authority, detachment, and emotional invincibility of the doctor-professor. Remaining mindful of research by on abuses of medical students (Sheehan et al., 1990), this transfer in identification may be understood as a process whereby students come to identify with hegemonic oppression, and in doing so paradoxically come to experience their patients' needs as oppressive.

Since a scientific medical model may not acknowledge that complications are sometimes inevitable despite good technological interventions and a skilled practitioner, physicians are may not have the tools to emotionally cope with disappointments in practice. Compounding this, medical training's focus on biology often fails to meaningfully address social, emotional, spiritual, or psychological aspects of experiences. Not only, then, do doctors receive minimal training focused on the non-physical needs of their patients, they also lack role models and theoretical frameworks that could help them understanding their own psychological needs and reactions. Though it may go against their personal values and gut instincts, students are taught

that the psycho-social-emotional complex is not only irrelevant but also potentially harmful to sound scientific practice, and trainees are given no medically compatible framework for managing their own psychological needs or those of their patients. Faced with fear, helplessness, guilt, and anxiety, and without the emotional support of role models, colleagues, or theory, the doctor's negative feelings become displaced onto patients and internalized in damaging long-term ways (Burack et al., 1999; Jiménez & Thorkelson, 2012; Konner, 1987; Meyer & Mendelson, 1961; Rossberg et al., 2008). As such, a parallel process appears to occur whereby medical students become not only less able to care for their patients, but also themselves.

As compared with the general population, doctors are more likely to have significant psychological vulnerabilities, more likely to suffer from problems with drugs or drinking, at a higher risk of developing stress-related problems such as depression and suicidality, more likely to suffer from work-related mental health disorders, and more reluctant to seek medical advice due to difficulties in adapting to the role of the patient (Field & Haslam, 2008). When data was collected from 499 members of the ACOG, virtually every obstetrician in the study reported having experienced the delivery of at least one stillborn baby (Goldenberg et al., 2013). Grief was the most common reaction reported by the obstetricians, with 53% of respondents reporting they experienced significant grief. Other common reactions were feelings of self-doubt, depression, and self-blame. For 8% of obstetricians in the study, the emotional difficulty of stillbirth delivery was so great that they considered leaving obstetric practice altogether. The obstetricians, who were in private practice, where a closer and more long-term bond may be formed with patients, felt substantially more grief and depression than their peers working in large hospital settings.

If the myth sold to medical students is that doctors can control the uncontrollable, then when a doctor's protocols and technologies fail, it can appear to doctors that they personally are to blame. In other words, the medical model's unrealistic expectations lead inevitably to a physician's misplaced sense of personal accountability. Of course doctors make mistakes, and surely sometimes clearer thinking, better skill acquisition, better tools, or different judgment could have led to an improved outcome. Sometimes, however, no amount of medical intervention can prevent negative patient outcomes. If the medical model and scientific knowledge are presumed to be infallible, physicians must either accept the flaws in their professional ideology or accept that their inadequacies have led to human death and suffering.

### **Psycho-socio-emotional Impacts on Women**

Dominant, culturally-entrenched (though often unspoken) assumptions about what women are like, how they should behave, and what type of care is most appropriate for them are evident in how both women and their providers approach the event of childbirth. Even in this modern era, women are most widely perceived as self-sacrificial nurturers (Williams, 2000). It intuitively seems, then, that in self-sacrificial and nurturing roles, female knowledge and authority would be most socially accepted and expected. In becoming mothers, however, most American women are dependent upon medical knowledge, institutions, and professionals, which tacitly and overtly establish what (technology) and who (physicians) truly possesses authority and expertise. Even in the throes of labor, many women do not feel comfortable being aggressive, assertive, or demanding of others (Martin, 2003). Rather than display these attributes, the mothers in Martin's study often chose not to ask for help and not to voice their discomforts or preferences. When women did scream, complain, or make demands during labor, (despite their attempts not to), they were highly apologetic. Having internalized pressure to be

good, nice, and nonthreatening, the perceived importance of performing this role is only compounded in medical settings, where a “good” patient is one who is passive, agreeable, and defers to the expertise of medical staff. Moreover, in maternal health settings, the safety of not only the woman-patient but also her unborn child is at stake, and women may feel deeply uneasy about being perceived as preferring their well-being over that of their child’s.

Some women who take a passive stance toward their care during their pregnancies and labors, deferring to their doctors’ advice and doing little research of their own, find that after their babies are born they feel a need to make sense of their experience (Davis-Floyd, 2003). Upon doing their own research after the fact, such women may feel angry, sad, and betrayed to learn that their interventions were unnecessary or caused other complications. The experience of receiving painful, frightening, unwanted, and/or unnecessary interventions and the co-occurring experience of feeling disempowered, violated, and/or frightened for personal safety or safety of one’s baby, often leads to serious mental health concerns (Kendall-Tackett, 2007). Such an experience can constitute a trauma, and therefore it is expected that some degree of depressed mood, anxiety symptoms, or post-traumatic stress disorder (PTSD) may result. As one mother explained, “I was traumatized because of the set of circumstances that resulted in my feeling confused, frightened, abandoned and unacknowledged, and fearful for my life and my child’s” (Brujin, 2008, p. 13).

To better understand women’s maternal experiences, a national survey gathered extensive data from 1,573 women (Declercq, Sakala, Corry, & Applebaum, 2006). More than 25% of women surveyed reported feeling “weak” and/or “overwhelmed” during their births (Declercq et al., 2006, p. 54). Of the 32% of women in the survey who had a cesarean birth, 25% reported feeling pressured to deliver surgically. The great majority of mothers who experienced

episiotomy (73%) stated that they had not had a choice in this decision. One collection cases and experiences of women entering motherhood with PTSD includes the story of Denise: At nine centimeters dilation, her doctor told her that her baby girl was too big and she needed a cesarean. The physician told her that her large baby would get stuck and be decapitated, then requiring surgery to remove the rest of the infant's body. Denise recalled, "[The doctor] was obviously angry with me... he flung his glove (which was covered with blood) all over me.... He even wrote in my chart that I told him I felt forced to have a C-section and that I called him mean" (Griebenow, 2006). Another participant in the same study reported that after her child's birth, she had flashbacks so intense that they interfered with nearly every aspect of her life, including lovemaking. She explained that whenever her legs were spread, she saw the faces of the hospital staff that treated her.

Despite such clear markers of post-traumatic stress, many women experiencing these issues may be told that they are struggling with the "baby blues," or even with post-partum depression (Soderquist & Wijma, 2006). While either may co-occur with PTSD, along with weepiness, anxiety, and depressed mood, symptoms of PTSD may include insomnia, irritability, panic attacks, nightmares about the birth, a desire to avoid the baby or anything related to the birth, feelings of detachment from loved ones, and a sense that some other disaster is imminent; this sense may manifest as suicidal ideation (American Psychiatric Association, 2013). These experiences are common enough that a wealth of formal and informal resources and networks now exist. Support groups such as Post-Traumatic Stress Disorder After Childbirth, the Birth Trauma Association, Improving Birth, and Solace for Mothers, are designed to help women who have experienced childbirth as traumatic. It is important for both the mental health and obstetric communities to take note of these organizations, as they may constitute the most centralized



expert knowledge on issues and conditions that are too-often formally underdiagnosed and/or unrecognized. To this point, an internet movement focused on facilitating mainstream exposure of these issues has developed, with campaigns such as The Exposing the Silence Project ([www.exposingthesilenceproject.com](http://www.exposingthesilenceproject.com)) and #BreakTheSilence<sup>7</sup> giving a voice to women and providing a platform for them to share their personal stories (see appendix A).

As with any form of trauma, there is no one type of experience that an individual will necessarily find traumatic. Interestingly, births perceived as traumatic by mothers were usually viewed as routine by the involved clinicians (Beck, 2004). Women who experience unexpected labor and birth interventions have an increased risk of postpartum depression (Creedy, Shochet, & Horsfall, 2000; Fisher, Astbury, & Smith, 1997; Koo, Lynch, & Cooper, 2003; O'Neill, Murphy, & Greene, 1990; Soderquist & Wijma, 2002). After interviewing 195 pregnant women, study authors found that women with unrealistic expectations of what their birth experience would be like were at higher risk of depressed mood following their births (Shub, Williamson, Saunders, & McCarthy, 2012). This is troubling because 48% of study participants believed they would birth without intervention, while in reality, at the time of publication, an average of only 21% of women birthed without intervention. This highlights the importance of communication between doctor and patient, and of transparency and availability of outcome and intervention rates for every obstetrician, and obstetrics has lagged behind other departments in increasing the accuracy and transparency of their performance records (Gilbert et al., 2013). Patients should be easily able to obtain statistics demonstrating the birth outcomes of their obstetrician and their obstetrician's delivery setting, especially given the wide range among intervention rates across individual doctors and hospitals. Furthermore, patients should be able to do so in a way that

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does not feel threatening to their doctor-patient relationship. While patients sign documents legally allowing their medical providers to perform any procedures they deem necessary, such documents are not necessarily written for a patient's education or benefit, but rather for the legal protection of doctors and hospitals. It is also worth wondering whether a woman in the throes of labor is always able to give meaningful informed consent—whereby she has heard all pros and cons, considered them, and felt empowered to decide what is best for her and her baby.

The legitimate expertise of doctors must be recognized and how doctors use the great responsibility that comes with their privileged position, knowledge-wise, is an important issue. If women are given choices and are fully informed, in advance, about every advantage and disadvantage of the various scenarios they are likely to encounter, it seems clear that a woman should be supported in selecting the best options for her body and her unique situation. However, at what point should a doctor attempt to work with a woman to critically think about her choices? If a woman desires a C-section because she is afraid of the pain and chaos of labor, should her doctor immediately schedule a C-section or, knowing the potential medical complications related to elective cesareans, suggest she read relevant materials and join a therapeutic group for childbirth readiness, then reconsider? The answers are not clear, and the questions are relevant because some women desire a planned cesarean when the surgery is not medically indicated, introducing a number of increased risks to both mother and baby (Declercq et al., 2006). Responsibility for seeking and acquiring the information relevant to personal health-related choices must also lie with the patient; it would be unfair to place the entire burden solely on medical providers and institutions. However, advising patients to take it upon themselves to become more personally involved seems like a fraught recommendation when patients may feel systematically disempowered by the spaces in which their care is provided and

by the inherent power imbalance in their doctor-patient relationships. The use of medical jargon that patients may not understand, hurried appointments, and a “doctor-knows-best attitude” may be considered normal care in contemporary American society, but for patients, these elements of doctor-patient interaction can encourage complicity rather than self-assertion.

Feelings of mistrust after a negative birth experience can make it difficult for women to return for follow-up care, trust other providers, and may lead to feelings of anger toward one’s partner for not somehow intervening on their behalf (Treat, 2012). Additionally, such feelings may extend to the healthcare system as a whole. As one mother explained:

After [my birth], when I read about how much better it is to walk during labor and about how anesthesia slows down labor and reaches the baby, I threw the book across the room and burst into tears. For a whole year I blamed myself. Then for another year I blamed the doctors. Now I blame our entire medical system. I have no trust in it anymore.

(Davis-Floyd, 2003, p. 244)

On a large scale, these instances have significant and widespread consequences:

A cause of obstetric litigation that we don’t hear much about is the betrayal and anger patients feel when their baby is damaged or dies. I believe these feelings are, at least in part, the result of false promises made by doctors and hospitals. The doctor’s superior knowledge and status are for the most part unquestioned and there is a belief (or hope) that the doctor can perform miracles. (Wagner, 2008, 107)

The doctor’s belief that problems are solvable through some combination of technology, surgical skill, and pharmaceutical knowledge, perhaps unspoken but communicated to patients through a doctor’s attitude and way of relating to both the patient and their pathology, comes to be a patient’s assumption. For women in labor, this belief may translate to an understanding that

even if interventions or hospital routines are experienced as uncomfortable, awkward, or painful, cooperating with them is acceptable if it assures positive outcomes. When the spoken or unspoken agreement that the medical model can guarantee a healthy mother and baby is broken, patients and their families may feel extremely angry and betrayed, and the presence of these emotions is the strongest predictor of a litigious patient.

In a systematic review of research concerning malpractice suits filed against doctors, concerns surrounding the patient-physician relationship was consistently an underlying factor of litigation rates (Huntington & Kuhn, 2003). When patients experienced a breakdown in their relationship with their physician, it most often manifested as unsatisfactory communication experiences. Patients cited doctors who would not listen, would not talk openly, attempted to mislead, or did not provide adequate warning and information regarding the risks of procedures. These complaints describe the patient's experience of not being given proper expectations for their care and not being meaningfully included in the decision-making process surrounding their care. In addition,

When physicians do not communicate caring concern, especially when the care is painful, difficult, or results in less-than-optimal outcomes...patients who express their anger and frustration may cause the physician to react defensively in a way that may be perceived as hostile or arrogant. (Huntington & Kuhn, 2003, p. 158)

Ultimately, patients conflate their feelings of being disrespected and disempowered with deciding that their care was sub-par.

## **Malpractice**

Obstetricians are some of the most commonly sued medical specialists, with 75% of obstetric practitioners sued at least once in the course of their careers (Lochhead, 1990). The

average obstetrician will spend nearly 15% of their career fighting malpractice claims (Anderson, 2013). As a result of the frequency of litigation against those in their field, obstetricians pay the second-highest liability insurance premiums of any medical specialty (exceeded only by neurosurgeons). Between 2009 and 2011, 51.1% of ACOG members reported making at least a single change to their practice due to the high cost of malpractice insurance (Lowes, 2012). For some of these doctors, the costs of practicing have become so high that they have decided to stop their childbirth duties altogether, changing specialties or working exclusively in gynecology (Anderson, 2013). One in seven obstetricians has eliminated their obstetrical duties as a direct result of unaffordable insurance and an outright fear of lawsuits (Lowes, 2012). This scenario is leading to a maternal care availability crisis across the country, particularly in non-urban areas with a relatively few inhabitants and/or in areas where average incomes are relatively low. With practice-related costs so high, it is simply no longer profitable for obstetricians to serve certain populations. Data from the ACOG projects a shortfall of between 9,000 and 14,00 OB-GYNS in the next 20 years and categorizes 20 states as currently in a “Red Alert” crisis mode—meaning the number of ob-gyns available at this time is not sufficient to meet patient needs (Anderson, 2013). The lack of obstetricians available and/or willing to serve all types of patients, especially in rural areas, has left some women needing to travel unreasonably long distances in order to receive care. With frequent check-ups required during pregnancy and the potential for labor to be fast, this lack of access to care leads some women to go without prenatal care. Consistent prenatal care has long been recognized as vital in ensuring positive maternal and infant health outcomes, and therefore in the long-run, the obstetric access to care crisis creates higher systemic costs (Liu, 1999). Moreover, systemic such stresses translate not only to higher costs but also to loss of human life, as “Women in rural

communities where obstetrical providers are scarce experience more complications during labor, have higher infant mortality rates, and generate higher obstetrical costs” (Pathman & Tropman, 1995, p. 460).

While ceasing obstetric practice due to astronomical practice costs and fear of litigation may certainly be understood as a defensive maneuver, for obstetricians, litigation-based decision making known as “defensive medicine” was common (Lowes, 2012). In their survey, 18.1% of obstetricians reported deciding to see fewer high-risk obstetric patients, 15.1% performed more cesarean deliveries, and 13.5% stopped performing vaginal births after cesarean deliveries (VBACs). A nationwide analysis of the effect of fear of litigation on obstetric care examined patient-level data on every woman who delivered in 2006 and cross-referenced these results with average state malpractice premiums (Zwecker, Azoulay, & Abenhaim, 2011). State malpractice premiums averaging over \$100,000 were associated with higher incidences of cesarean deliveries and lower incidences of VBACs. Ultimately, Zwecker et al. (2011) found that authors found that “Fear of litigation appears to have a marked effect on obstetric practice, particularly cesarean delivery” (p. 277). As much as it may feel to doctors that defensive obstetrics is a necessary evil of a system that has led them to feel more underpaid and more unsafe, and as ubiquitous as this strategy may be among practitioners, it is in fact a violation of a fundamental principle of medical practice, that whatever a physician does must be first and foremost for the benefit of the patient (Cheng et al., 2014).

In their review of hidden causes of malpractice lawsuits, Huntington and Kuhn (2003) appealed to their colleagues:

It is easy to blame insurance companies, plaintiff lawyers, and runaway juries for [the current medical malpractice crisis]. It is harder to examine our own practices and ask

ourselves what we could do to change patients' feelings...In this age of phenomenal technological innovations and highly successful treatments and cures, why is it that our customers, the patients, are dissatisfied with their health care to such a degree that they feel compelled to file a lawsuit? (p. 157)

Physicians are truly placed in a double bind. They are trained to become desensitized to emotional needs, and are then punished with significant legal, financial, and psychological, consequences for not being better able to implement humanistic aspects of care.

### **Cost and Quality of Care**

When doctors promote and rigidly adhere to a highly medically managed (and highly expensive) version of maternal care, they are simultaneously promoting the only type of care that they are trained to give and the type of care that only they can provide. The rates of technological, surgical, and chemical interventions during childbirth have soared in this country, alongside decades of research providing evidence that these interventions are themselves dangerous especially when performed unnecessarily. Moreover, these interventions are financially costly, sometimes exorbitantly so. According to Marsden Wagner (2006), "The maternity care establishment has been seriously challenged by the trend toward evidence-based practice in medicine" (p. 131). The ACOG has a three-tiered system of practice recommendations, as follows: A, based in good and consistent scientific evidence; B, based in limited or inconsistent evidence; and C, based in practitioner consensus or opinion (Wright et al., 2011, p. 505). According to a recent audit, barely 25% of the ACOG's guidelines for standard obstetric practices meet level A standards of good and consistent scientific evidence (Wright et al., 2011). Approximately 40% of guidelines were found to meet level B standards, and approximately 35% were based on level C standards (Wright et al., 2011).

The lithotomy position is a good example of a routine obstetrical standard of care that has well-known contraindications for patients. Adrienne Rich (1986) quoted a 1966 Textbook of Obstetrics and Gynecology as follows: “Use of the lithotomy position...greatly contributes to the convenience of the obstetrician. This advantage more than compensates for the somewhat unphysiologic posture and the discomfort of the position itself” (p. 146). In other words, the utilization of a physically unhelpful position, which itself introduces risks for certain complications of labor and delivery, is worthy of use as a routine intervention because it more easily enables medical staff to perform exams and further interventions. Other routine interventions, which are presented as non-medicalized and so automated that many women and their families may not even recognize them as interventions, include restriction of food and water, required wearing of medical gowns, and moving from room to room or wing to wing as needed based on hospital availability. These rules function, like the lithotomy position, pose no material benefit to a laboring mother or her baby. On the contrary, at the very least they are likely to make her uncomfortable. They are also likely to slow or stop her labor, as being cold, hungry, nervous, anxious, or afraid inhibits labor as part of an evolved response that women stop laboring when they feel physically or psychologically unsafe (Lederman, Lederman, Work, & McCann, 1979). It may be partially due to these early interventions, and partially due to the negative and fearful associations many people have with hospitals themselves, but it is well-documented that labor, even if well underway at home or in the car, often slows down or temporarily stops upon a woman’s arrival at the hospital (Bak, 2003). Although the medical model denies the significance of environmental ambiance in labor and delivery, “anything that causes fear or alarm” can interfere with labor (Wagner, 2006, p. 104). The individual and systemic problems introduced by this lack of adherence to medically sanctioned (i.e., scientific)



evidence is well-illustrated by the case example of Cesarean (C) sections in America. Prior to 2009, the C-section rate in America rose steadily for twelve years in a row, constituting a 50% increase over the prior decade (Osterman & Martin, 2013). From 2009-2012, the rate held steady at 31.3% of all births. This rate is a national average, with individual hospitals across the country ranging in their statistics, and in some cases reaching rates of cesarean delivery as high as 69.9% (Kozhimannil, Law, & Virnig, 2013). This is despite decades-old recommendations from the WHO stating that there is no justification for a C-section rate above 15% and that an ideal rate, which would indicate that the procedure is reserved for true emergency purposes, is between 5% and 10% (Betran, Torloni, Zhang, & Gu'lmmezoglu, 2016). Moreover, the WHO finds that any C-section rate above 15% is indicative of the system utilizing the procedure unnecessarily, inevitably resulting in unnecessary harm to mothers and babies. Even an elective C-section performed in a non-emergency situation has an almost three times greater chance of leading to maternal death than a vaginal birth (Wagner, 2006). Babies born by cesarean section are five times more likely than those delivered vaginally to develop allergies when exposed to dogs, cats, dust mites, and other common household allergies (Olejarz, 2013). Such babies are also more likely to be born in respiratory distress (Azad et al., 2013). Moreover, women who receive invasive, unwanted, and/or uncomfortable medical interventions during their births are at higher risk of feeling that they were not in control of their birth experience, perceiving themselves as having failed, and/or experiencing a traumatically frightening birth (Creedy et al., 2000; Fisher et al., 1997; Sodorquist & Wijma, 2002). Physically, following a surgical birth a mother must remain in the hospital for longer, may not be able to easily breastfeed or lift her baby, and may not be able to care for older children as her incision heals.

Despite these drawbacks the C-section rate remains twice that recommended by the WHO, and interestingly, C-sections are more often performed on women with private insurance, which provides doctors and hospitals with higher reimbursement rates, than women who are uninsured or covered by Medicaid (Henke, Wier, Marder, Friedman, & Wong, 2014). The American women most likely to get a C-section are white, married, and not only privately insured but are giving birth in private hospitals (Wagner, 1994). Interestingly, these women are, demographically speaking, at the lowest risk for facing complications that might necessitate a C-section; therefore, this situation constitutes a rare example of wealthy women receiving less-safe care than poor women. Moreover, women giving birth in for-profit as opposed to non-for-profit hospitals are 17% more likely to have a C-section (California Watch, 2010). According to the WHO, profit motives explain hospital-specific cesarean section rates that are high even by United States Standards (Wagner, 2006). An institution may need to perform enough C-sections to justify the costs associated with having an anesthesiologist on-call, and it is noteworthy that hospitals get reimbursed for C-sections at rates nearly double those for vaginal births.

Aside from cost issues, there is a convenience factor involved in an excessively high rate of surgical births, for doctors and sometimes for mothers as well. Not only are C-sections more commonly performed Mondays-Fridays during normal work hours, but even emergency C-sections are more commonly performed during this window, calling into question the truly emergent nature of such surgeries (Wagner, 2006). To the extent that obstetricians are not trained in managing normal birth, a C-section (surgery) fits much more comfortably with the training and perhaps interests of the obstetrician (surgeon), and therefore may be more psychologically, emotionally, and professionally convenient. This issue illustrates how medical

interventions, when overused, function to transform childbirth into a more efficient, predictable, and medically relevant process.

The wide application of many interventions during childbirth and the high costs of many of the chemicals, equipment, and labor necessary to perform these interventions can explain not only much of the \$98 billion dollars spent in America per year on hospitalizations for pregnancy and childbirth, but also can offer insights into the immense costs required to run our healthcare system as a whole (Childbirth Connection, 2010). Given that nearly half the population will experience pregnancy and childbirth at least once in their lifetime and that, unlike infectious diseases, these are not conditions that can be cured; the medical care that goes to their treatment constitutes a significant piece of the entire medical system's resources. Of those discharged from U.S. hospitals in 2009, 23% were new mothers and their newborns, and care for this population was by far the most common reason for hospitalization (Henke et al., 2014). "Mother's pregnancy and delivery" and "newborn infants" were the two most expensive hospital conditions billed to private insurance in 2008, involving 14% of hospital charges to private insurers, or \$50 billion (WHO, 2010). The average price for a normal vaginal delivery tops out at about \$4,000 in Sweden, France, and the Netherlands, all countries with excellent maternal and infant mortality rates (Rosenthal, 2013). In the U.S., the average price for a vaginal delivery is about \$30,000 (a 49% rise from 2004 to 2009) and \$50,000 for a C-section (a 41% rise from 2004 to 2009). For women who are uninsured or underinsured, huge costs may need to be paid out-of-pocket. In considering the impact of fear and anxiety on a woman's ability to birth her baby, what of families who enter the hospital financially dreading each intervention or each piece of equipment they may be applied to their delivery? One pregnant patient who was insured but whose insurance plan did not include maternity coverage, described her feelings of pre-labor

anticipation and worry: “I cannot stop worrying about potential delivery complications. I know that a C-section could ruin us financially” (Rosenthal, 2013, p. 8). At times, it can be challenging to understand exactly why giving birth in American hospitals is so expensive. Dr. Margaret Duane, a new mother and associate professor of family medicine at Georgetown Medical School, delivered her baby with a midwife within 12 minutes of arriving at her local hospital. She said of her birth, “It was the least medical delivery in history...no meds, no anesthesia, he was never in the nursery, I even brought my own heating pad” (Rosenthal, 2013, 5). She was therefore shocked when she received a large bill from the hospital. Dr. Duane described her difficulty getting clarification from the hospital about ambiguous charge categories such as “‘Maternity supplies.’ What was that? A diaper?’” (Rosenthal, 2013, p. 5).

While America’s system of care for pregnancy and birth is the most expensive in the world, we also have the worst rate of maternal death of any industrialized nation (Alkema et al., 2015). Obstetrician and professor at Harvard Medical School Neil Shah, M.D., estimates that unnecessary C-sections may be responsible for up to 20,000 major surgical complications per year (Haelle, 2017). According to a 14-year analysis of more than 2 million women in Canada, women with low-risk pregnancies undergoing their first C-section were three times more likely to die or suffer serious complications—such as blood clots, heart attack, and major infections—compared with women delivering vaginally (Liu et al., 2007). When it is revealed that America spends the most on medical care for pregnant and childbearing women and yet loses more mothers than any other comparable nation, it seems clear that the American use of expensive medical technologies is not the best allocation of resources.

## A Climate of Change

The medical industry in the United States, as a profit-driven and bureaucratically-entrenched enterprise, is becoming aware that the type of care they are providing is often not what patients want or need. In her editorial on compassion and the doctor-patient relationship, medical doctor Knight (2011) explained,

Patients are increasingly unhappy...more are turning to alternative medicine and systems of treatment...we need to see being compassionate as moving beyond the individual doctor to the profession as a whole. As patient feedback so often tells us, our patients value our caring, listening, and compassion and as we also know from the evidence, these virtues do result in better patient outcomes. (p. 15)

To stay truly competitive in any consumer-driven field, it is necessary for providers of a service to adapt to consumer's needs and desires. Pearlman and Gluck (2005) agreed, "Our specialty is threatened...and should position itself among the leaders of the patient safety movement" (p. 941).

American medical patients have increasing consumer power via their ability to give word-of-mouth recommendations, evaluate practitioners on a growing number of online domains, and their ability to research and potentially select physicians based upon publicly available reviews<sup>8</sup>. Interestingly, doctors have begun to regularly check their reviews online and have made changes as a result of the feedback (Reddy, 2014). If obstetricians take action to incorporate elements of mental and emotional health into their delivery of physical healthcare, they will be well-positioned to move toward a more effective, and popular, model of care.

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<sup>8</sup> Examples include: Healthgrades.com, Vitals.com, RateMDs.com, Zocdoc.com, HealthCareReviews.com.

When doctors empathically engage patients, they diagnose more accurately, and patients are more compliant with recommendations and feel more satisfied with their care (Fields et al., 2011). Similar improvements in communication and patient care can be expected when doctors attend to a patient's cultural identity, be it based in her ethnicity, nationality, age, religion, sexual orientation, disability, or socioeconomic status (ACOG Committee on Health Care for Underserved Women, 2011). Furthermore, possessing the skills to communicate in sympathetic, patient-centered, and culturally competent ways would provide physicians with the confidence needed to attempt such conversations. Too often, doctors ignore a patient's non-physical distress due to their own feelings of helplessness or sense that they must remain detached and objective (Rosenfeld & Jones, 2004). However, a patient may need a safe place to discuss their concerns more than they need a medical intervention. Rather than shrinking from patients who complicate standard exams with their psychological, emotional, and social needs and experiences, physicians should aim to become comfortable with those issues, even if that means having a relatively brief conversation and making an appropriate referral.

Dr. Howard Spiro (1993) described medicine as “both science and narrative, reason and intuition” and criticized the medical model's emphasis on scientific detachment and objectivity at the exclusion of empathetic understanding and connection (p. 14). Knight (2011) argued that the anecdote to the dominance of science and technology in modern healthcare is to reintroduce the value of the human touch into training. As evidenced by current levels of obstetricians' emotional distress, patients' dissatisfaction, the poor quality of maternal care, and rates of malpractice suits and insurance premiums, it is pressing that doctors adapt their conceptualization of care. Of equal importance is that women advocate for their right to receive care that meets the full range of their basic needs, is transparent and fully informative, and is safe

and evidence-based. The healthcare system, and all those who benefit from it, would be improved as a result of reducing costs associated with physician malpractice insurance, avoiding short and long-term costs associated with excessive gynecologic and obstetric interventions, and preventing short and long-term costs associated with harm to women's mental, emotional, psychological, and/or relational health. Moreover, these aspects of a woman's life frame how she parents, aspects of her relationship with her partner and her family-of-origin, her feelings about her work outside and/or inside the home, and how she understands her own identity. These qualitative and hard-to-measure factors nevertheless have highly a salient impact on the larger picture of what women and families in society are like, and what type of children they produce.

Reviewing the processes involved in obstetric training, practice, and regulation of practice, it becomes clear that a cacophony of interrelated forces creates an untenable scenario where the quality of maternal care is severely compromised and physicians and their patients alike are harmed. The current theory and culture that couches obstetric medicine prizes the heavy application of scientific knowledge and technological intervention and fails to facilitate the utilization of intuitive, emotional knowledge and humanistic approaches. The practice of this type of care has effectively weakened physician/patient relationships, contributing to very high rates of malpractice suits in the specialty. In turn, higher rates of litigation against obstetricians have ballooned the real and potential costs of practicing obstetric medicine, and contributed to pressure for practitioners to be more efficient and profitable and to practice defensive medicine. The roots of these issues may lie in missed opportunities to update and expand the medical training physicians receive. In a survey of 220 obstetricians and pediatricians, respondents reported receiving little information on psychological aspects of obstetric practice during

undergraduate or postgraduate medical training, or from voluntary continuing education programs (Chalmers & McIntyre, 1993). In discussing the implications of their review of empathy decline during medical school, Neumann et al. (2011) wrote,

On the basis of our findings that the clinical practice phase of training and trainee distress seem to be key determinants of empathy decline, we propose addressing these problems by testing different, sound interventions....which support students and residents by allowing them to discuss and reflect on issues of vulnerability and responsibility within the context of health care provision. (p. 1001)

What is promising is that research indicates that just as a medical student's empathy can be systematically deactivated, so can it be re-taught. A program aimed at reducing burnout and increasing empathy and interpersonal skills among obstetrics and gynecology residents found that, even 12 months after their participation in the program, residents demonstrated reduced levels of burnout and increased interest and confidence in handling psychological aspects of patient care (Ghetti, Chang, & Gosman, 2009). These are exactly the skills that are desired by unsatisfied patients and that consumer-driven hospitals would like to be able to advertise to patients.



### Chapter 3: Review of Existing Interventions

When examining the influences that disenable doctors from a practicing patient-centered medicine, and the resulting negative consequences for doctors, patients, and our healthcare system, existing perspectives on and approaches to this problem are of interest. Of specific importance for careful review are interventions that take the form of supplementary physician education, in order to ensure that my program i) does not duplicate something already in existence and ii) is evidence-based. Therefore, in my reading of relevant literature I specifically focused on programs consistent with mine in intention (for example, teaching doctors communication skills, humanistic approaches to medicine, integrated care) and/or in topic (obstetrics/gynecology). Given that the design of my program will be informed by knowledge of what interventions currently exist, how they are being applied, and how effective or ineffective they prove to be, I paid particular attention to methodology and outcomes. In my analysis, I have identified five sub-headings under which programs of interest for my review fall: Teaching Communication, Promoting Holism, Humanizing Medicine, Integrating Psychology, and Facilitating Self-Awareness.

#### **Teaching Communication**

In a paper on best methods for training medical students and residents to deliver bad news to patients, Loaiza and Arroyave (2009) quoted the AMA's first medical code of ethics, published in 1847:

The life of a sick person can be shortened not only by the acts, but also by the words or manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have tendency to discourage the patient and to depress his spirits. (p. 66)

While doctors often believe the words they use when delivering news are most important, patients usually recall vividly how the message was delivered and focus on the physician's manner and style (Loaiza & Arroyave, 2009). Training physicians to communicate effectively appropriately is crucial, because "delivering news inappropriately is distressing for both giver and recipient" (Loaiza & Arroyave, 2009, p. 67). Specifically, good communication between physician and patient is associated with increased patient satisfaction, increased patient adherence to treatment recommendation, and increased quality of life for patients; bad communication is associated with physician burnout and increased litigation.

The issue of communication is seen as particularly salient when the physician has bad news<sup>9</sup> to deliver, and for this reason a formal training program concerning bad news was designed, run, and evaluated (Loaiza & Arroyave, 2009). When delivering bad news, physicians tended to lecture about details and use scientific language, while patients are honed in on, and still digesting, the piece of negative information they have heard. To provide education and training on best communication techniques, medical students engaged in didactic and experiential learning. They were taught to stay silent in order to allow patients time for their emotions to set in, acknowledge and validate feelings, sit at eye level, and turn off cell phones and pagers. Additionally, students were instructed to mentally rehearse how to deliver their news and to prepare themselves emotionally prior to the discussion. To improve their technical skills and confidence, the students then engaged in various role-plays with cancer survivors. As compared with a control group, the medical students who completed this formal training in delivering bad news had more confidence and received better feedback from patients.

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<sup>9</sup> "Bad news" is defined as "Any information that is subjectively appraised by patients or their loved ones as negatively affecting their view of the future" (Loaiza & Arroyave, 2009, p. 65).

The issue of delivering bad news takes on a special relevance in obstetrics, as in the 1960s and 1970s most congenital abnormalities were diagnosed at the time of birth, and therefore the pediatrician largely addressed the family's grief and concern (Loaiza & Arroyave, 2009). Today, however, ultrasound technology provides increasingly accurate prenatal diagnoses and therefore obstetricians increasingly need to deliver challenging news to their patients. To address this issue, an educational conference on breaking bad news in obstetrics and gynecology was organized and evaluated (Romm, 2002). Resident physicians listened to a panel discussion of patient-educators discussing their experiences receiving bad news, both good and positive. Based upon the real-life stories of these patients, residents were then engaged in a discussion about what communication strategies are helpful and what should be avoided. They were provided with 10 "Do's:"

1. Arrange to have enough time to share the news without interruption.
  2. Pace the giving of information to what the patient can handle.
  3. Consider having printed information that addresses common concerns.
  4. Deliver the bad news as soon as possible, however do not call the patient at work.
  5. Say you are sorry for their bad news.
  6. Never say "I know how you feel" unless you've personally experienced what they are.
  7. Include the spouse, partner, family if the patient wishes.
  8. Non-verbal comforting gestures are often appreciated.
  9. Never leave a telephone message with bad news.
  10. Do not take away hope.
- (Loaiza & Arroyave, 2009, p. 178)

The residents who participated in this conference had unanimously positive feedback about the experience itself, and about their perception of its helpfulness in terms of their skills and knowledge.

Finally, a Canadian neonatal medicine residency program was designed to address the finding that fellows felt well trained in the medical aspects of neonatal care, but felt much less trained in addressing associated social and emotional issues (Daboval & Shidler, 2014). As a

result, a program, called Neonatal Critical Care Communication, was designed to help residents learn to deal with the complex and intensely emotional conversations involved in caring for sick newborns. Facilitators utilized improvisational theater training techniques, didactics about relationships, interdisciplinary studies, small group workshops, scenarios involving actors, and activities structured to promote self-reflection and inclusion of systemic perspectives. Daboval and Shidler (2014) found that education in communication skills must address knowledge, attitudes, and personal experiences, and should include opportunities to explore these areas and receive expert feedback. During workshops, teachers guided trainees by helping them recognize their emotional reactions and values while dealing with a given scenario, and to remain present and empathic while recognizing both personal and professional difficulties. This approach was utilized because “self-reflection is essential to develop effective communication skills in challenging clinical situations” (p. 23). Daboval and Shidler (2014) acknowledged the need for formalized pre and post-tests moving forward, but reported that qualitative and anecdotal feedback demonstrated that the program is highly effective. Additionally, “A dedicated competency-based program aimed at training very complex and interconnected skills should be implemented in every neonatal-perinatal postgraduate program... Trainees must be well-prepared in all human and professional dimensions” (Daboval & Shidler, 201, p. 25).

### **Promoting Holism**

A “holistic approach” to medical care may mean different things to different people in different settings. Some studies reviewed in this section are holistic in that they promote an understanding of health that extends beyond the biological realm, and others are holistic in that they promote medical collaboration with various related departments and subspecialists. All

seek to expand traditional understandings of medical education and/or standard healthcare delivery in ways that improve upon patient experiences and outcomes.

Hassed, (2004) discussed an Australian curriculum intended to introduce holism into mainstream medical education, and outlined associated challenges and successes. Program administrators found that “how messages are delivered to medical students are as important as the content” and that “challenges are as much personal as intellectual” (p. 406). Important factors for success of program content included environment, language, diplomacy, relevance, and evidence. Helpful factors for program facilitators included building positive relationships, being patient, being objective and impartial, and using humor.

Another educational initiative was designed to help students become “holistic and patient-centered, valuing and practicing both the art and the science of medicine” (Sturmberg, 2005, p. 236). The approach taken by administrators utilizes a model emphasizing that a patient should be in balance in four main areas: somatic (anatomy, physiology, pathology, genetics), social (family, housing, community, lifestyle), psychological (stress, anxiety, trauma, relational patterns), and semiotic (meanings assigned to illness, world, and self). This method emphasized teaching medical students to learn the components underpinning each of the four dimensions, understand the relationships and interconnectedness of each dimension, and to create an integrated healing plan for hypothetical patients.

Creators of a program for fourth-year obstetrics and gynecology students in London focused on “encouraging students to place less emphasis on a disease-oriented approach” (Nicholson, Osonnaya, Carter, Hennessy, & Collinson, 2009, p. 398). Students were instead guided to focus on understanding health promotion, humanism, normal processes of pregnancy and childbirth, and interdisciplinary care. Students learned these principles through a

combination of didactic and immersive experiences, and the majority of participants reported finding the program useful. A similar program, utilizing both didactic and experiential components but focused on improving rates of breastfeeding, was offered to 417 residents in pediatrics (Feldman-Winter, 2010). The curriculum provided students with self-study materials on anatomy, physiology, and basic skills related to breastfeeding. These materials were then the basis for discussion questions, didactic lectures, and skills workshops. Students were then guided in assisting three new mothers with breastfeeding, with at least one of the encounters observed and evaluated. Finally, clinical scenarios were discussed in small groups. Six groups of residents completed the program, seven control groups did not, and pre and post-tests were administered to all groups. Results found that program participants were more likely to show improvement in knowledge, practice patterns, and confidence related to breastfeeding help, and that infants in their care were more likely to be breastfed at six months of age.

A nurse-developed program designed to “bridge the gap between textbooks and maternity patients” and “enhance the ability to work on a multidisciplinary team” offered 350 first-year medical students the opportunity to interact with patients during and after delivery (Cooksey, 2010, p. 325). In these interactions, students provided support and companionship, not medical care. To prepare them to act in this role, students were taught to maintain eye contact with women, speak in quiet and soothing tones, listen for opportunities to educate, not assume every woman is happy to be pregnant, and to allow each woman her own unique reaction to her newborn before commenting on the baby. Additionally, students were encouraged to evaluate environmental conditions and activities affecting women, such as room cleanliness, temperature, lighting, noise, and frequency of staff’s coming and going. Students who participated in the program were shocked that women who entered the hospital visibly frightened and tense were

calmed by receiving their individual attention, “Even though they know we’ve never assisted in labor!” (Cooksey, 2010, p. 330). Some students also reported that witnessing babies separated from their mothers after labor, mothers receiving unnecessary interventions, doctors being uncaring, and obvious instances of lack of informed consent, were highly upsetting. Overall, students had consistently positive responses to their participation.

A unique program, proposed and evaluated for interest but not yet run at the time of publication, describes a merger between OB/GYN and midwifery students (Fraser, Symonds, Cullen, & Symonds, 2000). Fraser et al. (2000) posited that “collaboration and cohesive work between the two departments is necessary for first-class maternity services” and that “multiprofessional education can lead to more cohesive practice in healthcare, but brings organizational and attitudinal difficulties” (p. 180). Both medical and midwifery students were interviewed in order to discover their feelings about the potential merger. The majority of medical students (57%) believed they would benefit, specifically citing that the merger could aid in improving interdepartmental relations, provide them with a more holistic approach, and teach them about managing normal labor and delivery. An almost equal percentage of midwifery students (56%) did not believe they would benefit, stating that when envisioning the merger they saw a great potential for conflict, specifically because they felt that medical students were arrogant and had an exclusively scientific approach. One midwifery student stated, “I don’t think we would benefit although they might learn a thing or two—where communication skills are concerned—from us” (Fraser et al., 2000, p. 181). In some ways, these results demonstrate that medical students may be more open to collaboration and new approaches than they are perceived to be, as well as that they are not the only students who may consider their approach to be superior. Additionally, the midwifery students’ fixation on an anticipation of conflict and the

perceived unkindness of medical students suggests that they feel wary of and intimidated by medical doctors, and that these feelings constitute a barrier to more integrated and holistic care.

### **Promoting Humanism**

The very notion of the phrase “medical humanities,” in terms of physicians’ familiarity with and understanding of it, was the object of study in a qualitative analysis entitled “A Silly Expression” (Knight, 2006). Knight defined the “silly expression” as an integrated, interdisciplinary, philosophical approach to recording and interpreting human experiences of illness, disability, and medical intervention. Thus, it is inclusive of fields such as the arts and social sciences, and is concerned with how such outside perspectives may provide insight and understanding for medical practice. Lengthy interviews were conducted with 16 doctors in order to explore whether or not they were familiar with the idea of medical humanities, and if so, what it meant to them, and whether they considered it relevant to medical education and practice. Reactions were varied: some physicians had heard the term before, some were unsure what it meant, and some displayed contempt for the idea. Interestingly, most participants expressed attitudes and values consistent with those frequently associated with a humanistic perspective, but did not recognize them as relevant to their everyday practice of medicine. Knight (2006) posited that the inclusion of medical humanities in the curriculum for medical students can be viewed as a “vital step towards the development of a compassionate and reflective practitioner who understands patient’s needs” (p. 121). Moreover, she posited that integrating the arts and humanities in the understanding and practice of medicine promotes critical thinking about the medical model, aids students in developing a sense of social responsibility, and promotes a responsiveness to the existential dimensions of the patient encounter.



Given these potential benefits, it is of interest to discover the most salient ways of promoting these traits with a humanistic curriculum. Authors of a nationwide survey of fourth-year medical students and first-year residents from 20 American medical schools sought to discover what factors most influence the development of humanism in medical students (Moyer et al., 2010). Data from 80 focus groups suggested that the key influences on students' development of humanism were their authentic, unique, and participatory experiences during and before medical school, and having the opportunity to process those experiences. Students also reported that having positive role models had a great impact on the development of their humanistic traits as related to their clinical work. Another proven method for teaching humanistic qualities to medical students is incorporating the teaching of the liberal arts into medical education (Halperin, 2010). According to this inquiry into efforts to preserve the humanities in medical education, medical schools are increasingly including medical humanities programs and elective or required courses in their generalized medical curriculum; however, these offerings are generally dependent on the clinical revenue underpinning the department, have limited access to grants, and are often viewed as a diversion from “the real courses’ of anatomy, biochemistry, and surgery” (Halperin, 2010, p. 78). Milligan and Woodley (2009) advocated for an interesting use of the medical humanities—teaching ethics as a relational engagement. Their program, incorporating creative expression, such as the exploration and interpretation of poetry, art, music, and literature, was found to expand upon students' understandings of the illness experience and for supporting a relational approach to ethical issues in healthcare practice. First-year paramedic students were invited to produce their own creative composition in response to a short vignette describing the situation of a fictional “patient-other” (Milligan & Woodley, 2009, p. 131). Though they were initially apprehensive, the students

ultimately embraced the task and demonstrated great insight and sensitivity during the exercise. In a qualitative assessment of the intervention, students reported emotional and intellectual transformations that both challenged them and sensitized them to the deeper human dimensions of their work with patients.

### **Integrating Psychology**

A variety of programs designed to integrate psychological perspectives and skills into medical education, with the goals of improving the quality of patient care, improving doctor's self-awareness and mental health, improving systemic-level relations between medical professionals, and increasing doctor's openness to mental healthcare. This literature largely focused on the issue of countertransference, in terms of the negative impact it has on patients, doctors, and hospital systems, and evaluates strategies for helping physicians to become aware of and cope with their work-related reactions.

Pereira and Holanda (2013) created a program to address "lack of integration of health topics in medical school and a lack of preparedness for work with real patients" that "conflicts with the aims of medical school" created a mental health practicum for first-year medical students (p. 513). The main objective of the program was to address students' stigma toward mentally ill patients and to increase empathy toward them. Results indicated that a collaborative approach and early exposure was able to increase the humanistic attributes of first-year students. Authors propose that more complex mental health courses should be offered to more senior medical students. An Australian program is putting this recommendation into place, teaching psychological processes and psychotherapy techniques to medical students (Seizer, Ellen, & Adler, 2015). Program developers report that the process of teaching these topics is as important as the content included in a program; in other words, they emphasize the importance of

developing rapport with the students and ensuring they understand how information is relevant to them and their patients. According to their feedback, the most salient topics to teach medical students are cognitive-behavioral interventions, systems theory, and countertransference.

The issue of countertransference<sup>10</sup> emerges in the literature as a largely unrecognized and unconscious yet highly salient factor of the doctor-patient relationship (Alfandre, 2009). When physicians recognize and respond appropriately to countertransference, there is great potential to improve patient care. Unrecognized feelings and emotions can distort how a physician interprets a clinical encounter and responds to a patient, and therefore understanding the role of countertransference creates real opportunities to improve patient care. Moreover, patient and physician satisfaction improves and physicians practice medicine more effectively and empathically when they pay attention to their own feelings (Halpern, 2007; Kane, 2012). Despite these recognized potential benefits, attempts to teach physicians to recognize countertransference have failed to permeate non-psychiatric medical training (Alfandre, 2009). There are a number of barriers to effectively teaching countertransference to medical students which would need to be addressed and overcome if it can be done successfully. For one, it is a skill that must be developed and cultivated over time, and “not all physicians may be psychologically minded or have the capacity or will for the kind of internal emotional work that understanding and integrating countertransference demands” (Alfandre, 2009, p. 38).

Despite these challenges, a survey of resident attitudes regarding their training in managing and mediating their own reactions to their work indicated that residents across the United States expressed a desire for more didactics, supervision, rounds, and case conferences

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<sup>10</sup> Countertransference may be understood as encompassing the nuances of all interpersonal interactions, as both conscious and unconscious, and inclusive of the entirety of emotions that clinicians feel toward their patients (Jimenez et al., 2012).

focused upon this skill set (Jimenez & Thorkelson, 2012). Residents surveyed reported that dynamic and relational factors are inherent in the interactions between doctors and patients, as well as within hospital or practice-wide systems, and that these factors can act as both a tool as well as an obstacle. Intensely negative countertransference encountered in medical and surgical settings have been described (Groves, 1978; Nash, 2009). Clinicians in medical settings navigate intense emotional reactions while caring for vulnerable and ill patients, but their lack of understanding of patients as people may compound their dehumanization clinical care, leading to a view of the patient as simply a problem or difficult case. Some of the patient characteristics most likely to evoke negative countertransference reactions from clinicians are the “hateful” patient, the “whining self-pitier,” and the suicidal patient (Jimenez & Thorkelson, 2012, p. 440). Simultaneously, characteristics of physicians that lead them to particular susceptibility to countertransferential responses include perfectionism, guilt, exaggerated sense of responsibility, chronic self-doubt, conflicted attitudes toward anger and dependency, fantasies involving rescue or omnipotence, dislike or fondness for a patient, and optimism or pessimism regarding prognosis. Significantly, countertransference has been recognized as an important factor in passive aggressive, self-defeating, and avoidant behaviors toward patients, which are reactions that contribute to patient-perceived abandonment and punishment (Rossberg, Karterud, Pederson, & Friis, 2008). In addition, lack of patient adherence to medical recommendations and negative outcomes are increased in clinical scenarios involving negative countertransferential reactions from the physician toward the patient (Jimenez & Thorkelson, 2012). Holmqvist (2011) stressed the responsibility of the clinician to attempt to discover a patient’s influences on his or her reactions, indicating a need for examining the clinician’s own inner world. In 1970, Massachusetts General Hospital “famously” implemented weekly self-awareness sessions

focused on encouraging the identification of subjective reactions to clinical scenarios and teaching about how to utilize these emotions clinically, mitigate potentially negative outcomes of such reactions, and discuss feelings with fellow staff (Jimenez & Thorkelson, 2012, p. 445). Physicians were taught to recognize which of their bodily sensations indicated potentially problematic countertransference responses. Finally, program leaders created a forum where staff were encouraged to share feelings induced by their hospital work.

Healthcare providers often experience feel, frustration, and anger regarding their work environment (Meyer & Mendelson, 1961). In a 1997 survey of psychiatrists, poor quality of care was identified as the primary consequence of negative countertransference, while increase in conflict among staff was recognized as secondary outcomes (Wile, 1972). In an analysis by researchers at Northwestern University's Feinberg School of Medicine, 18 qualitative focus groups with obstetricians and anesthesiologists sought to explore the quality of inter-team communication during labor and delivery (Grobman et al., 2011). Study authors concluded that poor communication on the labor and delivery unit, specifically rude and unprofessional behavior and interactions, was recognized as a major contributor to occurrence of adverse events. Moreover:

Although such adverse events occurring in labor and delivery accounted for less than 10% of all inpatient adverse events identified in two large studies, medical malpractice claims against obstetricians are two to three times higher than the average for all other physicians. (Grobman et al., 2011, p. 243)

Although poor communication within labor and delivery teams is identified as a major contributor to the occurrence of adverse events, there have been few if any attempts to administer communication training for an inpatient obstetrical environment (Grobman et al., 2011).

## **Facilitating Self-Awareness**

When one considers the abundance of research articulating the effect of medical school on students' ability to empathize and the resulting negative impacts on patient outcomes, patient satisfaction, physician well-being, and inter-team communication, it is important to examine existing efforts to enhance physicians' emotional intelligence and introspection. Shapiro (2008) argued that such efforts are difficult for two primary reasons: i) medical students have complex and unresolved emotional responses to illness, disability, and death, that they must confront in the process of patient care, and ii) modernist assumptions about the capacity to protect, control, and restore are imbedded within the institutional culture of mainstream biomedicine and create inherent barriers to empathic relationships. Thus, in the absence of appropriate discourse about how to emotionally manage distressing aspects of the human condition, "it is likely that trainees will resort to coping mechanisms that result in distance and detachment" (Shapiro, 2008, p. 1). For these reasons, Shapiro (2008) suggested the need for a paradigm shift that will enable trainees to develop a tolerance for imperfection in themselves and in others, cope with emotional vulnerability and suffering, and reduce feelings of anxiety and threat in the presence of illness. Through such efforts, trainees may learn to emotionally contain the suffering of their patients and themselves, thus providing a foundation for the development of meaningful empathy in medical settings.

When it comes to the relationship between physician personal awareness and empathic patient caregiving, physicians' knowledge of their personal characteristics, past experiences, values, attitudes, and biases can have positive effects on their abilities to effectively communicate and care for patients (Novack, Suchman, & Clark, 1997). To promote the acquisition of personal awareness, Novack et al. (1997) proposed a curriculum of four core

topics for reflection and discussion with medical students, “because medical training and continuing education programs rarely undertake an organized approach for promoting personal awareness” (p. 504). These topics are i) physicians’ beliefs and attitudes, ii) physicians’ feelings and emotional responses in patient care, iii) challenging clinical situations, and iv) physician self-care. Specifically, these topics may be addressed in various formats including support groups, didactics, and discussions, and should ultimately facilitate student participation in a formal interpersonal skills curriculum. The authors note that however well physicians understand the science of medicine, they ultimately use themselves to practice its art; for this reason, achieving greater personal awareness enables them to “calibrate their instrument” (Novack et al., 1997, p. 507). As is consistent with studies previously reviewed, authors found that when medical students gain experience with these activities, they improve the quality of clinical care they provide and increase their satisfaction with work, relationships, and themselves. Interestingly, the authors made an explicit parallel between psychological and medical training, noting that

Mental health professionals...participate in reflective educational exercises...and monitor their emotional responses to inform the therapeutic process for the patient’s benefit.

Because medical practitioners routinely work with patients in emotional pain, frequently discuss sensitive issues, and counsel people experiencing minor and major stressors, it would seem essential that they have similar training...Yet, medical schools do not offer this training, and worse, they promote self-defeating attitudes and behaviors that may hinder the development of personal awareness. (Novack et al., 1997, p. 503)

A final set of publications highlights the overarching challenges and promise of educational efforts encouraging students to engage in activities that may be unconsciously

understood as explicitly taboo according to mainstream medical culture. Medical education does more than teach knowledge and technical skills; “it also inculcates a specific set of attitudes, values, beliefs, and behaviors” that authors term *DoctorThink* (Hanson & Callahan, 1999, p. 182). These authors ask: what sort of medical practitioners should our society aim to produce? They assert that *DoctorThink*, defined as an “diagnose-and-treat paradigm and culture,” privileges the goals of diagnosing and treating disease, and in doing so “necessarily impoverishes other goals, such as prevention of illness, relief of suffering, and care for those who cannot be cured” (Hanson & Callahan, 1999, p. 192). As a result, there is a need for an alternative model that can educate doctors not just for diagnosing and treating but for providing preventative and supportive care. An initiative at Boston University, was designed to teach medical students activities promoting self-reflection, self-awareness, collaborative learning, and applied practice (Wiecha & Markuns, 2008). The students who participated in this curriculum reported feeling more confident in the clinical realm overall, and felt that they had gained skills in each of the identified areas.



## Chapter 4: Original Research

In August of 2015, I collected data from residents and physicians working in the area of obstetrics and gynecology in order to formally assess the need for my program. I created a 10-question survey (see appendix B) and circulated it via email. The questionnaire assesses the extent to which practitioners feel they were well-trained to recognize and care for psycho-social-emotional issues related to their specialty, the extent to which they encounter such issues in their practices, their comfort level when dealing with those issues, and their interest in obtaining additional training on these topics. It also assesses the physician's own psychological, social, and emotional needs and reactions to their work, training, and patients. Participants were located utilizing word-of-mouth referrals and connections, and through the kind participation of the Chicago Gynecological Society (CGS). After contacting CGS and describing my project, they agreed to include a link to my survey in their member-wide email for the month of August. All research participants viewed an informed consent page, and after agreeing to the terms were directed to the survey itself. I was ultimately able to obtain the participation of 13 physicians in various stages of their careers. I then engaged in a qualitative analysis of the data collected.

### **Results**

Fortuitously, my participants represent a relatively equal scatter in terms of career experience. At the time they were surveyed, 30% of participants were residents, 23% had been in practice for 0-10 years, 23% for 10-20 years, and 23% for 20+ years. This data is portrayed below.

Table 3

Responses to Question #1: Please describe current occupation and years in practice.

<b>Participant #</b>	<b>Area of practice</b>	<b>Years in practice</b>
Participant 1	Obstetrics/Gynecology	4 years
Participant 2	Obstetrics/Gynecology	23 years
Participant 3	Obstetrics/Gynecology	11 years
Participant 4	Obstetrics/Gynecology	30 years
Participant 5	Obstetrics/Gynecology	Resident
Participant 6	Obstetrics/Gynecology	8 years
Participant 7	Obstetrics/Gynecology	Resident
Participant 8	Obstetrics/Gynecology	Resident
Participant 9	Obstetrics/Gynecology	16 years
Participant 10	Obstetrics/Gynecology	Resident
Participant 11	Obstetrics/Gynecology	12 years
Participant 12	Obstetrics/Gynecology	2 years
Participant 13	Obstetrics/Gynecology	25 years

In response to two relevant survey questions, 69% of respondents felt their medical school did not pay sufficient attention to the emotional, psychological, and social aspects of women's reproductive health, and a smaller 46% felt their residency training did not pay sufficient attention to those issues. It is understandable that residency training would do a better job than medical school at providing in-depth training, as it is specific to a certain area of practice. However, that nearly half of physicians in this study are reporting that their ob/gyn-specific residencies did not sufficiently train them in non-medical aspects of women's reproduction is problematic. I wanted to discover if these responses followed a pattern related to years in practice. Data indicated that training, particularly residency training, is becoming more comprehensive, as represented below.

Table 4

Sorted by years in practice—responses to Question #2: In your opinion, did your medical training pay sufficient attention to the emotional, psychological, and social aspects of women’s reproductive health? and Question #3: In your opinion, did your residency training pay sufficient attention to the emotional, psychological, and social aspects of women’s reproductive health?

<b>Respondents by Years in Practice</b>	<b>Medical Training?</b>	<b>Residency Training?</b>
Resident 1	No	Yes
Resident 2	No	Yes
Resident 3	Yes	Yes
Resident 4	No	Yes
0-10 yr Practitioner 1	Yes	Yes
0-10 yr Practitioner 2	No	Yes
0-10 yr Practitioner 3	No	No
10-20 yr Practitioner 1	Yes	Yes
10-20 yr Practitioner 2	Yes	No
10-20 yr Practitioner 3	No	No
20+ yr Practitioner 1	No	No
20+ yr Practitioner 2	No	No
20+ yr Practitioner 3	No	No

Significantly, even of respondents who reported feeling that they received sufficient training in psycho/socio/emotional aspects of women’s’ reproductive health, 82% of respondents reported that they would be interested in further training. Respondents were also asked to identify the specific areas they were interested in knowing more about. Table 5 represents their responses, arranged from most to least common area of interest:

Table 5

Percentage of Respondents Who Stated Their Desire for More Training in Each Area

<b>Training Topic</b>	<b>Percent of Respondents</b>
Accommodating patient’s emotional/psychological issues	64%
The mind/body relationship	55%
Helping patients make decisions	45%
Working with diverse populations	36%
Recognizing patients’ emotional/psychological issues	36%
Communicating with patients	36%
Recognizing own work-related emotional reactions	27%
Managing own work-related emotional reactions	27%
Alternative medicine	27%

I was interested in how the area(s) each respondent identified as topics they wanted to learn more about might translate to challenges they currently face in their practice of medicine. I compared the above table to the tables below, and discovered some interesting correlations.

Table 6

Responses to Question #9: What are your greatest challenges, overall, when working with pregnant, laboring, and postpartum women?

<b>Greatest Overall Challenges When Practicing Obstetric Care</b>	<b>Percent of Respondents</b>
Lack of time	62%
Caring for patients who reject medical recommendations	54%
Caring for patients who have negative outcomes	46%
Legal/malpractice concerns	38%
Discomfort with patients who become overly emotional/overshare	15%
Discussing the psycho/socio/emotional aspects of women's health	7%
Discomfort discussing patients' fears and negative emotions	7%
Hospital policies	7%
Feeling burned out	7%

Table 7

Responses to Question #6: In your opinion, which factors represent the most significant roadblocks to practicing patient-centered medicine?

<b>Most Significant Roadblocks to Practicing Patient-centered Care</b>	<b>Percent of Respondents</b>
Lack of time	100%
Discomfort with patients who become overly emotional/overshare	23%
Discussing the psycho/socio/emotional aspects of health	23%
Legal/malpractice concerns	23%
Discomfort discussing patients' fears and negative emotions	15%
Discomfort becoming too intimate with patients	15%
Feeling burned out	15%
Hospital policies	15%
Private practice policies	7%
Challenges collaborating with nurses	7%
Desire not to become emotionally involved with work	7%
Belief that medical doctors should be objective	7%

Of the 54% of respondents who felt that "Patients who reject medical recommendations" constitutes a most significant overall challenge in obstetric work, 71% also expressed a desire for

further training in managing their own work-related emotions, and/or, managing their patients' emotions. This is interesting because it demonstrates how compliance and power dynamics in medical contexts may relate to deeper relational issues such as trust, effectiveness of communication, and quality of rapport. The strong correlation between concerns about patient compliance and concerns about both doctor and patient emotions suggest that these issues go hand-in-hand.

In contrast, of the 46% of respondents who felt that "caring for patients with negative outcomes" constitutes a most significant overall challenge in obstetric work, 80% also stated that they desired further training in recognizing and/or managing patients' emotions. However, only 20% stated that they desired further training in recognizing/managing their own emotions. This may indicate that when facing negative outcomes, physicians are rightfully concerned about their patients' psychological and emotional well-being. Simultaneously, it may reflect that in these situations they are either less aware of how they themselves are being impacted emotionally, or are less willing or able to become in touch with that impact.

Of the 38% of respondents who felt that "malpractice/legal concerns" constitutes a most significant overall challenge in obstetric work, 71% also stated a desire for further training in communicating with patients and/or helping patients make decisions. This is striking given the amount of research indicating that the quality of the doctor-patient bond and communications are more predictive of a malpractice suit than actual medical mistakes. It may be that the physicians in my study are aware of this research, and as a result are actively seeking to bolster their communication skills. It may also be that participants who are more anxious about malpractice also have a sense that they are not communicating very well with their patients.

In identifying which issues are specific to women's health practitioners, it is noteworthy that although participants were given the same list of issues to choose from when citing their greatest challenges in terms of obstetric work and in terms of practicing patient-centered medicine generally, a few answers appeared exclusively regarding obstetrics. Moreover, those answers were the second and third most popular responses. The most common answer for the question regarding greatest challenges in obstetric work, endorsed by 62% of respondents, was "lack of time." The second most common answer, endorsed by 54% of respondents, was "caring for patients who reject medical recommendations" and the third, endorsed by 46% of respondents, was "caring for patients who have negative outcomes." In contrast, for respondents answering the question regarding greatest challenges in patient-centered medicine generally, 100% named "lack of time;" none endorsed "caring for patients who reject medical recommendations" or "caring for patients who have negative outcomes." These results indicate that the latter two issues are relatively specific to the practice of obstetric medicine, confirming research regarding women's growing dissatisfaction with and/or mistrust of obstetric medicine, as well as that regarding obstetricians' personal difficulty with negative outcomes such as stillbirths.

Finally, while 38% of respondents stated that their greatest challenge in obstetric work was "legal/malpractice concern," a lesser 23% endorsed this item when considering their ability to practice patient-centered medicine more generally. This disparity likely reflects the particularly high rates of lawsuits filed against obstetricians, as compared with other medical specialists, and as a result of ensuing anxiety, could indicate that defensive medicine (defined as involving extra medical interventions) is consciously or unconsciously being practiced.

## Chapter 5: Program Development

To address the gap between the type of care obstetrics and gynecology patients often receive and the type of care many of those patients may need and desire, I have outlined a psychoeducational program for residents and doctors working in obstetrics and/or gynecology. The program takes the form of workshops that can be attended by groups of eight to ten people, and may also be broken into smaller components such that it could function as a medical school elective. The primary goals of this program are as to work with doctors to achieve the following:

- Process the experience of working as a physician with pregnant and birthing woman.
- Introduce and explore a humanistic medical approach to conceptualizing women's reproductive experiences.
- Build empathy for and enhance identification with patients.
- Educate about psychological, social, and emotional issues related to pregnancy and childbirth.
- Encourage interdisciplinary collaboration by providing information about non-medical sources of support and how to effectively identify and refer patients in need of mental healthcare.
- Teach skills basic to patient-centered counseling and patient-driven decision making.
- Encourage a fluid understanding the culture of medicine in the context of patients' value systems.
- Facilitate a reconnection with core-values as healers and explore how these values can lead to increased work-related meaning and more authentic patient interactions.

The program will be formulated and led from humanistic-existential and psychodynamic-relational perspectives that are non-pathologizing, experiential, and interested in individual processes of meaning-making. It is designed explicitly to offer an unconventional accompaniment to the medical model's normative approach to women's reproductive health by educating practitioners about relevant psychological theories and techniques and alternative

perspectives in women’s health. Simultaneously, it is intended to complement the existing system of care. This approach will avoid identifying with either the natural or the medical model. One way of thinking about the integrative model advanced by the program is by understanding the medical approach as high tech/low touch, the natural approach as low tech/high touch, and this approach as high tech/high touch (Davis-Floyd, 2004).

Table 8

## Caring for the Whole Woman: A Program for Practitioners of Obstetrics and Gynecology

<b>Module</b>	<b>Description</b>
Introduction	<ul style="list-style-type: none"> <li>• Ice-breaker</li> <li>• Team-building exercises</li> </ul>
Medical Humanities	<ul style="list-style-type: none"> <li>• Break into small groups; each group is given a phenomenological description of pregnancy/birth/postpartum based in art, poetry, personal narratives. Share and discuss reactions.</li> <li>• Discuss how communications relate to our own opinions, issues, biases, cultures.</li> </ul>
Transference/Countertransference	<ul style="list-style-type: none"> <li>• Exploring our own values and beliefs</li> <li>• Learning about how personal views and experiences influence relationships and communication</li> <li>• Learning to identify personal reactions and triggers</li> <li>• Learning how emotions can be diagnostic</li> </ul>
Communication Skills	<ul style="list-style-type: none"> <li>• Patient-centered communication</li> <li>• Motivational interviewing</li> <li>• Informed consent</li> </ul>
Systemic Issues	<ul style="list-style-type: none"> <li>• Malpractice and relationships</li> <li>• Adherence and relationships</li> </ul>
Physician Self-care	<ul style="list-style-type: none"> <li>• Burnout</li> <li>• Vulnerability and being the “help-ee”</li> <li>• Practicing authentically</li> </ul>
Obstetrics: Mind and Body	<ul style="list-style-type: none"> <li>• Learning about factors involved in whole health</li> <li>• Appreciating their interconnectedness of these factors and using this knowledge to analyze cases and create healing plans.</li> </ul>
Referrals	<ul style="list-style-type: none"> <li>• What complimentary services and practitioners are relevant to ob/gyn patient populations</li> <li>• When and how to refer patients to relevant specialists</li> </ul>



## Chapter 6: Discussion

Psychologist Gayle Peterson (1996), who specializes in perinatal mental health, wrote about how her own clinical experiences demonstrate our culture's mishandling of birth and the detrimental impact this has on the female psyche. Birth can be both intensely frightening and intensely ecstatic. It is nature at its most impressive and its most threatening; it is an explicitly biological event, yet is a culturally constructed and highly social female rite of passage. An understanding of maternal processes as not simply biological events but also as social, cultural, and intensely personal has the potential to expand what women, their families, and their healthcare providers expect from birth, and expectations can shape lived experiences.

The implications of a psychoeducational program for physicians working in women's reproductive healthcare, if designed and carried out sensitively and thoroughly, are likely to be significantly effective for providers of obstetric care, patients of obstetric care, and our healthcare system as a whole. Effects may be observed in the short and long-term, in both systems and individuals. Expected impacts include, but are not limited to:

- Increase in collaboration and integration of care between non-medical members of the maternal care community (doulas, midwives, childbirth educators, lactation consultants, prenatal yoga instructors, specialized physical therapists, and others) and medical members of the maternal care community (obstetricians, gynecologists, primary care doctors, nurses, anesthesiologists).
- Increase in doctors' confidence, sense of mastery, ability to integrate personal values into care, contextualized knowledge of maternal health and care, and an increase in ability to manage their own emotions and psychological needs.

- Improvement in the doctors' communication and relational skills and ability to manage patient's emotional and psychological needs.
- Increase in the quality of patient care as evidenced by increased patient satisfaction.  
Doctors completing this program may expect to have increased referrals through word-of-mouth.
- Decrease in patient's short and long-term emotional and physical injuries and complications.
- Decrease in incidences of traumatic birth experiences, and a decrease in post-partum depression and anxiety triggered by such experiences.
- Decrease in short and long-term health costs.
- Decrease in the rates of malpractice suits for doctors completing the program.
- Higher quality experiences for women and their families including women's increased confidence about themselves, their bodies, and their abilities to mother.

If projected impacts are found to be true results of the program's implementation, a number of future implications for the program are indicated. First, it may be adapted to become a standard or elective part of medical education and/or residency training. Second, integrative care, increasingly recommended for all specialties of medicine, could become the norm in maternal care. Three, it could be worthwhile to pursue accreditation through the AMA and/or ACOG in order to have the program certified as constituting a portion of the Continuing Education Requirements for physicians. If this effort was successful, the program (in whole or in part), could be presented at private practices, hospitals, and at conferences.

By carefully adapting and customizing the program to existing and collected data and research, the program attempts to represent the stated needs of both patients and physicians. One

element of this representation is acknowledging that not all people want the same thing for their care or have the interest or ability to practicing medicine in the same way. Therefore, the program will seek to present numerous points of view and will encourage customized and individualized approaches. In terms of managing conflicts inherent in disrupting hegemonic theories and techniques, the program will be sensitive to the medical culture and understanding that it can be natural for professionals with extensive training to resist learning new and different ways of thinking about their work. The hope is that physicians' own experiences of psychological discomfort, and of observing the limitations of an exclusively objective approach to patient care, will create the motivation to incorporate new skills and perspectives. Finally, the program's administration must attend to the emotions in the room and create a best environment for learning, personal growth, and critical thought.

### **Future Directions**

Some preliminary limitations of the program may be identified here, though more may become apparent once the program is being run. Given that the participant pool contributing to primary, original data was relatively limited in size (13 physicians), and that survey results indicated that the culture of training is becoming more humanistic over time, it may be advisable to repeat and broaden data collection in five to ten years. At that point, questions can be more carefully honed and more medical contacts will have been made, hopefully ensuring a wider pool of participants. At some future time, it may be helpful to amend questions as relevant, in order to re-assess the goodness of fit of the program for physicians' wants and needs. In this version of the survey, physicians were asked how comfortable they feel referring patients for complementary services (acupuncture, massage, chiropractic care, physical therapy), as well as for services addressing psychological and emotional concerns (therapy, birth or postpartum doula

care, support groups). Respondents unanimously reported feeling comfortable referring for psychological/emotional care services, and 92% reported feeling comfortable referring for complementary services. In a future edition of the survey, it would be of interest to discover how frequently these referrals are actually occurring.

Based upon a review of existing programs and feedback from practicing obstetricians, a number of future directions for this program are implicated. The possibility of bringing in women who experienced traumatic as well as positive births to speak with program participants and share their stories could be a powerful intervention, as demonstrated by other programs utilizing direct patient interaction. Potential patient-participants would have to be properly vetted for preparedness and appropriateness for the encounter, and informed of the potential for triggering latent trauma.

Once running, this program will need to be assessed for quality and efficacy. Moving forward, outcome measures will need to be developed in order to ensure that participants feel that the program is helpful and meets their training needs (see Appendix C). Additionally, it would be ideal to survey the patients of physician-participants in order to assess whether or not patient satisfaction increases following the program participation of providers. Finally, tracking physicians' patient outcomes and rates of malpractice would enable an evaluation of whether these are improved through program participation. Future versions of the program could be amended as necessary based upon these outcome measures.

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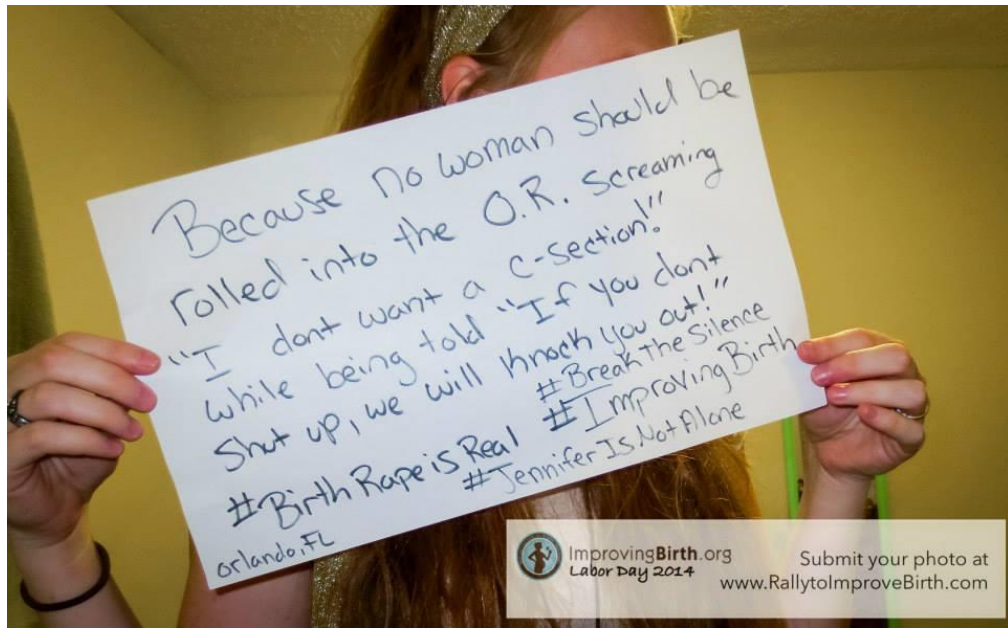
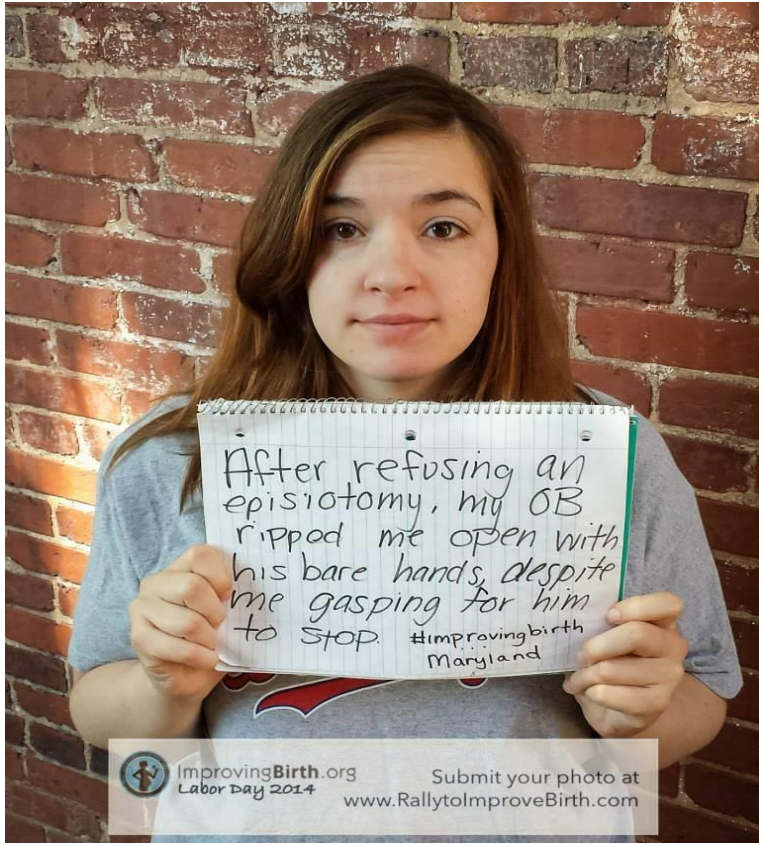
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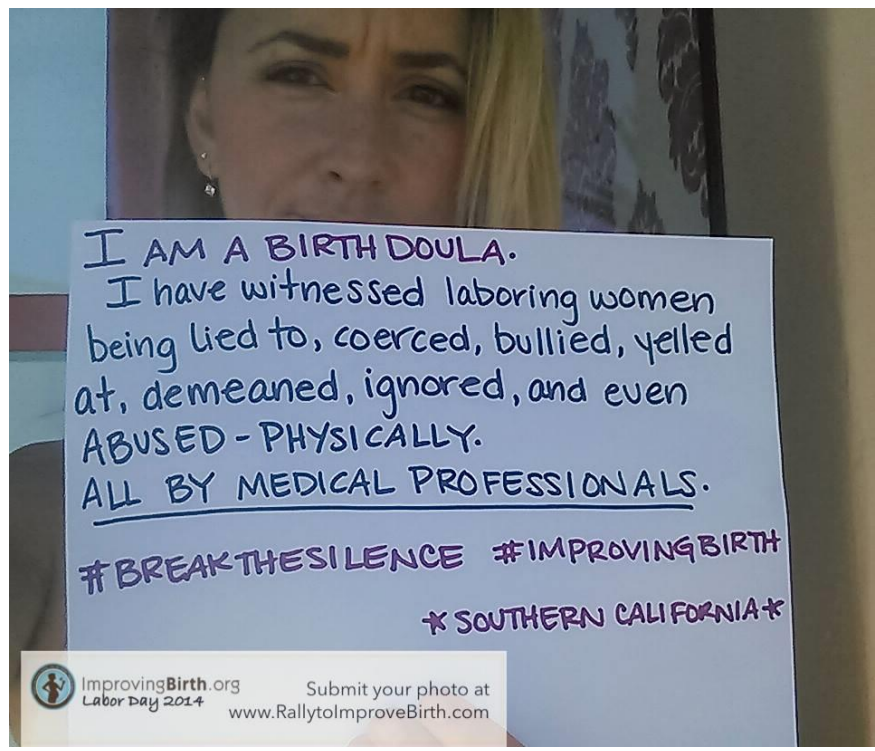
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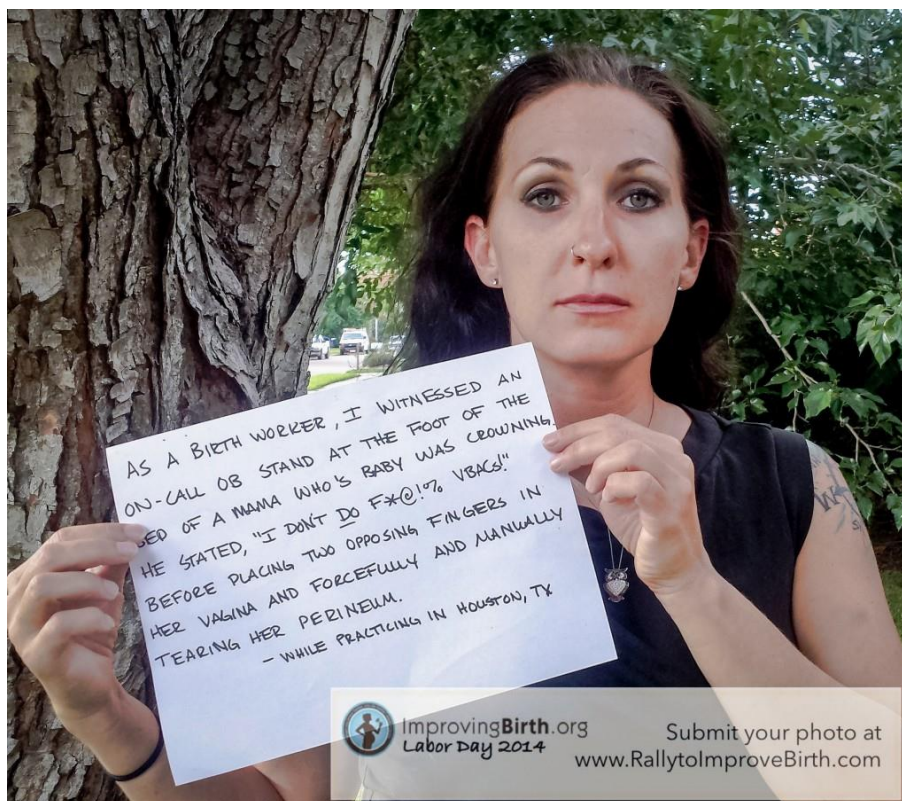
Appendix A: Traumatic Birth Experiences from ImprovingBirth.org

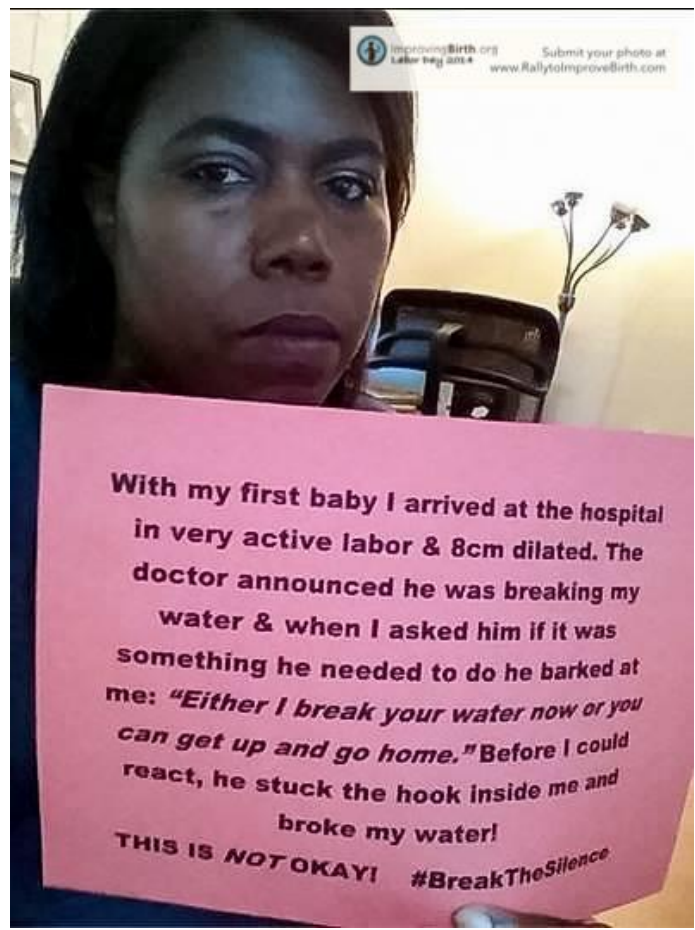
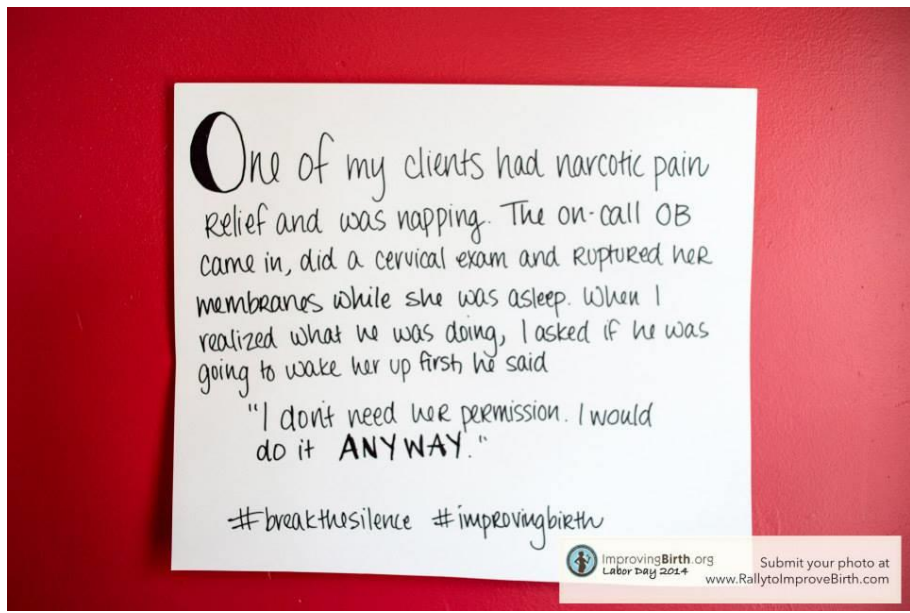












Dawn Thompson

4/18/16

Erika,

Thank you for seeking permission. We appreciate it very much. You are welcome to use the campaign, we just ask that you credit ImprovingBirth for the material. I'd love to see the finished product.

In love and service,

Dawn Thompson  
President, ImprovingBirth

*"Working to Bring Evidence Based Care and Humanity to Childbirth"*

## Appendix B: Research Survey

**1. Please describe your current occupation and years in practice.**

**2. In what area of medicine did you complete your residency?**

**3. In your opinion, did your medical training pay sufficient attention to the emotional, psychological, and social aspects of women's reproductive health?**

- Yes  
 No

Why or why not?

**4. In your opinion, did your residency training pay sufficient attention to the emotional, psychological, and social aspects of women's reproductive health?**

- Yes  
 No

Why or why not?

**5. Which of the following were addressed during your medical school and/or residency training? Please select all that apply.**

- Communicating with patients  
 Helping patients make decisions  
 Working with diverse populations  
 Alternative medicine  
 Mind/body relationship  
 Recognizing patient's emotional/psychological issues  
 Accommodating patient's emotional/psychological issues  
 Recognizing your own work-related emotional reactions  
 Managing your own work-related emotional reactions

**6. In which of the following areas would you like to receive further training? Please select all that apply.**

- Communicating with patients
- Helping patients make decisions
- Working with diverse populations
- Alternative medicine
- Mind/body relationship
- Recognizing patient's emotional/psychological issues
- Accommodating patient's emotional/psychological issues
- Recognizing your own work-related emotional reactions
- Managing your own work-related emotional reactions

Other (please specify)

**7. In your opinion, which factors represent the most significant roadblocks to practicing patient-centered medicine? Please select all that apply.**

- Feeling burned out
- Hospital policies
- Private practice policies
- Lack of time
- Belief that medical doctors should be objective
- Discomfort becoming too intimate with patients
- Challenges collaborating with nurses
- Desire not to become emotionally involved with work
- Legal/malpractice-related concerns
- Discomfort discussing the social/emotional/psychological aspects of women's health issues
- Discomfort discussing patient's fears and negative emotions
- Discomfort with patients who become overly emotional or overshare during appointments

Other (please specify)

**8. Are you comfortable referring patients for complementary medicine services (acupuncture, massage, chiropractic, physical therapy)?**

- Yes
- No

**9. Are you comfortable referring patients for services addressing psychological/emotional concerns (therapy, birth or postpartum doula care, support groups)?**

- Yes  
 No

**10. What are your biggest challenges, overall, when working with pregnant, laboring, and postpartum women? Please select all that apply.**

- Feeling burned out  
 Hospital policies  
 Private practice policies  
 Lack of time  
 Belief that medical doctors should be objective  
 Discomfort becoming too intimate with patients  
 Challenges collaborating with nurses  
 Desire not to become emotionally involved with work  
 Legal/malpractice-related concerns  
 Discomfort discussing the social/emotional/psychological aspects of women's health issues  
 Discomfort discussing patient's fears and negative emotions  
 Discomfort with patients who become overly emotional or overshare during appointments  
 Caring for patients who reject medical recommendations/care  
 Caring for patients with negative outcomes (e.g. stillbirths, miscarriages, premature births, other complications)  
Other (please specify)

## Appendix C: Likert-Scale Post-Test

After participating in this workshop:

- I have learned more about childbirth
- I have an expanded view of the nature of my job
  
- I am more likely to recommend doula care
- I am more likely to refer for mental health care
  
- I will be able to take better care of my patients
- I will communicate better with patients
- I will be better able to coordinate patient care
  
- I have more empathy for my patients
- I care more about helping my patients meet their non-medical needs
  
- I feel less afraid of being sued
- I feel less judgmental of my patients for their choices
- I feel less uncomfortable with my patients' emotions