Coming to Know What Happened: Participatory Clinical Decision-Making Process among Thai Pregnant Women with Preterm Labor

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Nursing (International Program)

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ชื่อเรื่องวิทยานิพนธ์ กระบวนการเรียนรู้การมีส่วนร่วมในการตัดสินใจทางคลินิกในหญิงไทยตั้งครรภ์และมีภาวะเจ็บครรภ์ก่อนกำหนด

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บทคัดย่อ

การมีส่วนร่วมในการตัดสินใจทางคลินิกเป็นสิ่งที่มีคุณค่าและมีผลต่อความพึงพอใจของผู้ป่วยต่อระบบบริการสุขภาพ อย่างไรก็ตามองค์ความรู้เกี่ยวกับกระบวนการมีส่วนร่วมดังกล่าวในมุมมองของผู้ป่วยยังมีอยู่น้อย การศึกษาครั้งนี้จึงมีวัตถุประสงค์เพื่ออธิบายกระบวนการการมีส่วนร่วมในการตัดสินใจทางคลินิกในหญิงไทยตั้งครรภ์ที่มีภาวะเจ็บครรภ์ก่อนกำหนดโดยวิธีวิจัยเชิงทฤษฎีพื้นฐาน (grounded theory) เก็บข้อมูลโดยการสัมภาษณ์เจาะลึก การสังเกต และการศึกษาบันทึกสุขภาพของผู้ป่วย ผู้ให้ข้อมูลคือหญิงไทยตั้งครรภ์และมีภาวะเจ็บครรภ์ก่อนกำหนดจำนวน 26 คน ซึ่งเข้ารับการรักษาในโรงพยาบาลของรัฐ 2 แห่งในกรุงเทพมหานคร วิเคราะห์ข้อมูลโดยวิธีเชิงเปรียบเทียบ (constant comparison) และการให้รหัสข้อมูล (coding) ผลการศึกษาได้แสดงให้เห็นถึงกระบวนการเรียนรู้การมีส่วนร่วมในการตัดสินใจทางคลินิกในหญิงไทยตั้งครรภ์และมีภาวะเจ็บครรภ์ก่อนกำหนดประกอบด้วย 2 ระยะ คือ ระยะก่อนเข้ารับการรักษาในโรงพยาบาลและระยะเข้ารับการรักษาในโรงพยาบาล ซึ่งแบ่งออกเป็น 5 ขั้นตอน ได้แก่ 1) การตระหนักในสิ่งผิดปกติที่เกิดขึ้นและผลกระทบ 2) การสืบเสาะหาผู้ช่วยเหลือ 3) การประเมินสถานการณ์ทางคลินิก 4) การมีส่วนร่วมในการตัดสินใจทางคลินิก และ 5) การเข้าใจในสภาวะการณ์ที่เกิดอะไรขึ้น ซึ่งปัจจัยที่ทำ

ให้เกิดกระบวนการดังกล่าวประกอบด้วยระดับการศึกษาของผู้ป่วย สัมพันธภาพในครอบครัว ความรุนแรงของอาการผิดปกติ บุคลิกภาพของผู้ป่วย ประสบการณ์เกี่ยวกับการเจ็บครรภ์ก่อนกำหนด ข้อมูลที่ได้รับเกี่ยวกับภาวะเจ็บครรภ์ก่อนกำหนด สัมพันธภาพระหว่างผู้รับบริการและผู้ให้บริการ ศักยภาพของผู้ป่วยในการติดต่อสื่อสาร ทัศนคติของผู้ให้บริการและนโยบายของโรงพยาบาลเกี่ยวกับการมีส่วนร่วมในการตัดสินใจทางคลินิก อิทธิพลของวัฒนธรรม และความคาดหวังของผู้ป่วยเกี่ยวกับการรักษาพยาบาล ผลการศึกษาดังกล่าวช่วยให้เกิดความเข้าใจในกระบวนการมีส่วนร่วมในการตัดสินใจทางคลินิกและให้แนวทางในการสนับสนุนหญิงไทยตั้งครรภ์ให้มีส่วนร่วมในการตัดสินใจทางคลินิกโดยเฉพาะในระยะที่มีภาวะเจ็บครรภ์ก่อนกำหนด

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ABSTRACT

Patient participation in clinical decision-making is valuable and has an effect on satisfaction with health care services. However, there is limited knowledge about this process from the patients' perspective. Thus, the purpose of this study was to explore the process of participatory clinical decision-making among Thai pregnant women experiencing preterm labor. A grounded theory method was used in this study and data were collected by in-depth interview, observation, and reviewing patient records. The participants were 26 Thai pregnant women diagnosed with preterm labor and admitted to two public hospitals in Bangkok, Thailand. Constant comparison and a coding process were conducted. "Coming to Know What Happened," the evolving model of the study was identified. The model was used to describe pregnant women that were facing preterm labor while participating in clinical decision-making. The model consisted of two phases: a pre-hospitalized phase and a hospitalized phase which are divided into five stages: 1) recognizing that something was wrong and its impact, 2) seeking help, 3) assessing the clinical situation, 4) taking part in clinical decision-making, and 5) understanding what happened. The factors that influenced the process included the educational level, family relationship, severity of symptom, personality, past experience regarding preterm labor, information related to preterm labor, relationship between the patient and the health care provider, communication skills, health care provider's attitude and hospital policy regarding participation in clinical decision-making, cultural influence, and expectation of care. The findings provide greater understanding of the participatory clinical decision-making process and can be used to guide interventions for encouraging Thai pregnant women to participate in clinical decision-making.

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CHAPTER 1

INTRODUCTION

This chapter describes the background and significance of the study, the objective of the study, the research question, the scope of the study, and definition of terms.

Background and significance of the study

Preterm labor is still the leading cause of perinatal mortality and morbidity in worldwide and Thailand. The preterm baby is at significant risk for long-term disability and there is the possibility of psychological stress for infants and their families. These physical, emotional, and financial problems may be devastating and life altering (London, Ladewig, Ball, & Bindler, 2003; Weiss, Saks, & Harris, 2002). The rate of preterm birth among women in the United States has steadily risen from 12.1% in 2002 and 12.5% in 2004 (Reedy, 2007). Asian women were at 6.8% in 2002 and 10.4% in 2004 (Palmer & Carty, 2006). In Thailand, its incidence varied between 8% and 15% in 2003 (Phupong, Charakorn, & Charoenvidhya, 2004).

Preterm labor leads to low birth weight (Blondel et al., 2002; London et al., 2003; Moore, Ketner, Walsh, & Wagoner, 2004; Newton, 2004; Pompeii, Savitz, Evenson, Rogers, & McMahon, 2005; Simpson, 2004). Infant birth weight is the determining factor of a neonate's ability to survive, and of the extent to which neurological, psychological, and physical sequelae follow (Magowan, Bain, Juszczak, & Mclnneny, 1999; Moore et al., 2004; Reedy, 2007). Respiratory distress syndrome

(RDS), the most common problem among preterm babies, is the second most expensive hospital diagnosis in the United States (Jijon & Jijon-Lefort, 1995). Health care dollars today focus on the "rescue and rehabilitation" of the preterm infant. Preterm babies are often the highest cost population for health care insurance companies (Jones, Istwan, Jacques, Coleman, & Stanziano, 2002). The increased human and dollar costs for special education, rehabilitation for physical handicaps, life-long care, and family support are in the millions of dollars per family. The medical and economic consequences of preterm delivery include five million hospital days per year at a cost of over five billion dollars, and these figures do not include projected additional costs for rehospitalization, special education, long-term or even custodial care for survivors with chronic illness or handicaps (Murphy, 1993). In Thailand, the total cost for preterm babies is 2,300 million baht ($0.67 billion dollars) annually (Ministry of Public Health Board, 2002). Thus, the prevention of preterm birth may be the most important issue for maternity care.

Untreated preterm labor usually results in preterm birth. Women with early pregnancies typically seek care for suspected preterm labor, when the earlier diagnosis is made and therapeutic intervention initiated. The perinatal mortality and morbidity associated with preterm birth decreased with advancing gestational age and birth weight (Magowan et al., 1999). Draper, Manktelow, Field, and James (1999) studied the prediction of survival for preterm births by weight and gestational age. They revealed that Asian infants exhibiting a gestation period of 22 weeks were predicted to survive irrespective of their size. The predicted survival at 28 weeks' gestation was 69% for a birth weight of 500-749 grams and 90% for those of 1250-

1499 grams. The predicted survival at 32 weeks' gestation was 96% for birth weights of 750-999 grams and 99% for those of 1500-2499.

With technological advances in the management of preterm labor, pregnancy may be prolonged; fetal survival rates have increased and morbidity has decreased (Goldenberg, 2002; Reedy, 2007). However, the current treatment modalities are consequences of physiological, psychological, and functional for the women, the pregnancy and the family as a whole. Consistent with Maslow's Hierarchy of Needs, the expectation would be that physiological needs would be the priority over maternal psychological and functional needs. Consequently, women experiencing the onset of preterm labor face difficult choices related to the well-being of their fetus, self, and family. Preterm labor also changes the nature of the pregnancy experience from a joyful development event to an unexpected medical complication.

Management of preterm labor and preterm birth accounts for health care expenditure of over three billion dollars per year (Goldenberg, 2002). Strategies to prevent preterm birth have focused on early diagnosis of preterm labor and on clinical markers, such as cervical changes, uterine contractions, bleeding per vagina and changes in the fetal behavioral state. However, diagnosis with these clinical markers is dependent on the woman's recognizing a change in her pregnancy and initiating contact with the health care provider (Murphy, 1993). In order to prevent preterm birth or improve fetal outcomes, early diagnosis is crucial. Early diagnosis of preterm labor is difficult and has a high false-positive rate that can result from errors in testing (Newton, 2004). False diagnoses of preterm labor can result in unnecessary and potentially hazardous treatment for thousands of pregnant women (Wheeler, 1994). Improved methods of early diagnosis would be a significant advance in the treatment

of women at risk for preterm labor. Because of the risks involved in pregnant women experiencing preterm labor, these women should have the right to participate in their own health care; the right to make informed decisions is important in these cases. The pregnant women can make decisions by being concerned about the well-being of the baby. However, the decision that is the best for the baby might not be the best for the mother because of the side effects of treatment.

In the past, patients were expected to be passive recipients of nursing care (Biley, 1992). However, over the past few years, nursing literature has begun to suggest that the nurse-midwife should encourage his or her patients to play a more active role, especially to participate to a greater extent in the decision-making process regarding their own clinical care (Neufeld, Degner, & Dick, 1993; Sainio, Eriksson, & Lauri, 2001; Sainio & Lauri, 2003; Saunders, 1995). In recent years, a shift has moved from the paternalistic approach whereby only physicians can make treatment decisions, to the approach that many patients, when properly informed and supported, are capable of participating in making choices (Neufeld et al., 1993). Sutherland, Llewellyn-Thomas, Lockwood, Tritchler, and Till (1989) have stated that there are ethical, legal, and social reasons for this change occurring: ethically, where there has been a change from a paternalistic philosophy of care to one in which autonomy and patient self-determination are promoted; legally, particularly in the area of the need for informed consent; and socially, with the growing movement of advocating the view that the patient is a health care consumer. Participation at this level is between paternalism and autonomy, with patients and physicians/nurse-midwife taking part in the decision-making process (Guadagnoli, 1998). Nurse-midwives should respect individual rights and allow the patient to participate in clinical decision-making

(Henderson, 2003). This will enable patients to manage their health problems more effectively (Cahill, 1996). Involvement in treatment decisions also allows patients to take more control of their health care problems and thereby improve the outcomes (Mahler & Kilik, 1990). Saunders (1995) has stated that patient participation is an active process that involves patients performing clinical or daily skills, or partaking in the decision-making process from the time of admission until discharge.

Recently, patient participation in medical treatment decisions and in decisions concerning nursing care has become an important issue because patients are viewed as consumers of the health care system that are requested to make a choice in respect to their own health care. An increasing freedom of choice and patients' rights are being emphasized in modern health policy and in the legislation of many countries (Pelkonen, Perala, & Vehvilainen-Julkunen, 1998). Patients in many countries have been encouraged to participate in clinical decision-making by bringing the issue of patients' rights into the public arena (Beaver, Luker, Owens, Leinster & Degner, 1996). For example, in the United Kingdom, focusing on the patient as a consumer has been promoted through the Government White Paper, which endeavors to promote individual responsibility and self-determination as a hallmark of consumerism (Trnobranski, 1994). In Australia, the initiative of promoting patient participation in the decision-making process is based on two premises, i.e., patients have the right to participate in their own health care, and the patients' quality of life is much improved when they are able to assist in determining their own future (Barry & Henderson, 1996). In Finland, the patient bill of rights has strengthened the self-determination of patients in their health care (Pelkonen et al., 1998); and in Thailand, the Ninth National Health Development Plan also emphasizes health promotion by

encouraging people to participate in the decision-making regarding their own health care (Ministry of Public Health Board, 2002). As article 16 of the Thai law concerning national health states, a person has the right to be protected in the consumption of health care: to receive safe, quality and standard public health services; to receive accurate and adequate information; and has the freedom to choose and to use health services. In addition, the Declaration of Patient's Right 1997 (B.E. 2540) stipulates that every patient has basic right to receive health services as legally enacted in the Thai Constitution B.E. 2540, which states that all persons have equal rights to receive standard public health services, and have freedom of choice in medical treatment.

Although nurses generally support patient decision-making and value patient autonomy, the successful achievement of patient participation is not a simple matter. In practice, Saunder (1995) found that nurses are reluctant to encourage patients to participate in decision-making, for many reasons. First, they feel threatened by patients that take a dominant role in their partnership or by being asked too many questions. Second, they view that patients prefer to take responsibility for their health care on the hand of health care providers. Third, they perceive that their roles may be eroded when there is more emphasis on patient participation and self-care. Finally, they usually assume that tasks will be completed more quickly and thoroughly if each patient remains a passive recipient of nursing care.

According to many studies (Ashworth, Longmate, & Morrison, 1992; Neufeld et al., 1993; Pelkonen et al., 1998; Sainio & Lauri, 2003), patients' participation in their own care and involvement in decision-making have many beneficial outcomes, such as enhancing the patients' self-esteem and sense of control, promoting greater

efficacy of their health education, improving their compliance, enhancing goal attainment, shortening the length of hospital stays (Lott, Blazer, & West, 1992), increasing their responsibility for their own health care, and perceiving greater satisfaction with care (Ashworth et al., 1992; Avis, 1994; Cahill, 1996; Hanuchareankul & Vinya-ngug, 1991; Rudman, El-Khouri, & Waldenstrom, 2007; Saunder, 1995; Stower, 1992). Therefore, patient participation has greater benefits for patients, health care providers, and health care organizations.

Recently, patient participation in clinical decision-making has been one of the indicators of patient satisfaction in hospital accreditation (Hodnett, 2002; Lott et al., 1992; Suominen, 1992). Existing literature regarding participatory clinical decision-making has focused on medical and surgical patients (Avis, 1994; Biley, 1992; Suominen, 1992; Waterworth & Luker, 1990). In maternity care, patient participation has been studied during the delivery phase (Galotti, Pierce, Reimer, & Luckner, 2000; Pelkonen et al., 1998). However, to date, there have been no studies among pregnant women experiencing preterm labor that are among the high risk group and that are in greater need of clinical treatment and nursing care. Clinical treatment focuses on the health of pregnant woman and on the life of her fetus. The Bill of Rights among pregnant women ensures their right to participate in decision-making involving their well-being and that of their fetus, unless they need a medical emergency treatment that inhibits their participation (Ellis & Hartley, 1995). According to feminist opinion, pregnant women are often viewed as inferior, with less negotiating power because of the traditional notion in Thai society that the husband is the leader, supporter, and protector of his wife. The wife is expected to respect, comply with, obey, and honor her husband (Boonmongkol, 2000; Suphametaporn, 1999). Thai

social status, in particular gender roles, is also socially constructed and clearly defined in Thai society. Women are always subordinate to men (Bandhumedha, 1998). A "good woman" must be passive, quiet, obedient, and patient in accordance with her lower gender role (Suphametaporn, 1999). Thus, health care providers need to be concerned with soliciting the pregnant women's participation in the clinical decision-making process. Unfortunately, there is no study within the Thai context.

Most of the studies are conducted from the medical and surgical patient's and health care provider's perspective. Using standardized instruments may not be sensitive enough to capture the feelings, thoughts, and meaning of the participatory clinical decision-making process. Western literature cannot clearly describe how pregnant women experiencing preterm labor participate in clinical decision-making in the Thai culture context. In addition, the results from the pilot study also showed that all of the pregnant women disclosed that they would like to participate in clinical decision-making. Therefore, a study on the processes of participatory clinical decision-making among Thai pregnant women experiencing preterm labor is very much needed.

Although participation in clinical decision-making is an abstract concept, it can be enhanced by being placed within the context of a dynamic process rather than a static situation; therefore, a grounded theory approach was the preferred methodology for this study. This method enabled the researcher to develop an explanatory theory of the phenomenon and to identify the social processes of Thai pregnant women regarding preterm labor. Thus, this study contributes to nursing sciences by providing nurses with an understanding of the processes of participatory clinical decision-making among pregnant Thai women experiencing preterm labor.

Moreover, pregnant women experiencing preterm labor that participate in clinical decision-making are expected to gain beneficial outcomes, i.e., enhancement of self-esteem, a heightened sense of control, enhancement of responsibility for their own health and self-care, improved satisfaction in health care services, and prevention of preterm birth (Ashworth et al., 1992; Rudman et al., 2007; Sainio et al., 2001; Saunder, 1995; Speedling & Rose, 1985; Wittmann-Price, 2004).

The grounded theory method was considered to be appropriate for this study as it could explore the participatory clinical decision-making of Thai pregnant women experiencing preterm labor, including their perceptions and interactions. Moreover, this approach was able to uncover Thai pregnant women's perceptions of the meanings of the processes involved in preterm labor and the ways in which they interpret these processes. The purpose of the grounded theory is to describe the stages and processes of a particular experience (Chenitz & Swanson, 1986; Morse & Field, 1996). As participatory clinical decision-making is a process entailing change over time, grounded theory is suitable for exploring the participatory clinical decision-making of Thai pregnant women experiencing preterm labor.

Objective of the study

The objective of the study was to explore the process of participatory clinical decision-making from the perspective of Thai pregnant women experiencing preterm labor.

Research question

This study focused on the research question: What are the processes of participatory clinical decision-making among Thai pregnant women experiencing preterm labor?

Scope of the study

This study was conducted among Thai pregnant women experiencing preterm labor that have received treatment and nursing care provided by obstetricians and nurse-midwives during their pregnancy from in-patient and out-patient services at two public hospitals in Bangkok, Thailand.

Definition of terms

1. Participatory clinical decision-making regarding preterm labor

Participatory clinical decision-making regarding preterm labor refers to the processes of actions among pregnant women when facing the onset of preterm labor and interacting with health care providers when selecting treatments or care alternatives in clinical settings.

2. Pregnant women experiencing preterm labor

Pregnant women experiencing preterm labor refers to pregnant women that have had regular uterine contraction that has caused progressive cervical dilation of 2-

3 centimeters after 28 weeks and before 37 completed weeks of gestation, requiring clinical treatment and nursing care from health care providers.

CHAPTER 2

LITERATURE REVIEW

The purpose of this chapter is to review the literature that addresses pregnant women with preterm labor, patient participation, factors influencing participation in clinical decision-making, participatory clinical decision-making process among pregnant women, feminist theory, and grounded theory methodology.

Pregnant women with preterm labor

Preterm labor is labor occurring before 37 weeks of gestation (Buckley & Kulb, 1990). It is the presence of contraction of sufficient strength and frequency to affect on progressive effacement and dilation of the cervix before 37 weeks' gestation. London et al. (2003) stated that prematurity continues to be the number one prenatal and neonatal problem in the United States, with 11% of all live births occurring prematurely. Unfortunately, despite this impact and the massive use of material, effort, and money, the incidence of preterm birth has remained stable for more than 25 years. To be successful in reducing the incidence of preterm birth, a much better understanding of the causes and mechanisms of preterm birth is needed. The risk factors of preterm labor, diagnosis of preterm labor, effect of preterm labor on maternal; fetal; and family, management of preterm labor, and prevention of preterm labor will be presented.

Risk factors of preterm labor

The primary risk factors for preterm labor are having experience of preterm labor and preterm birth. Hoffman and Bakketeig (1984) found that a woman with one preterm birth has twice the risk for another, with three or more preterm birth. The risk in a subsequent pregnancy was five times higher than women who did not have a previous history of preterm birth.

History of premature prolonged rupture of membranes is also a risk factor for recurrence of preterm labor. Lee, Carpenter, Heber, and Silver (2003) found that women with a history of premature prolonged rupture of membranes had a 16% to 32% rate of repeat premature prolonged rupture of membranes in subsequent pregnancies. Assisted reproductive technology alone is a risk factor for preterm birth whether the pregnancy is a singleton or multiple gestations (Blondel et al., 2002). Multiple gestation and polyhydramnios are factors that increase the risk for preterm labor probably secondary to distention of the uterus and/ or increased pressure on the cervix (Reedy, 2007).

According to sociodemographic factors, low socioeconomic status is associated with preterm labor but probably because of other factors that keep women in/ near poverty. For example, poor women tend to be younger, single without support in the home, and poorly nourished, and have a higher prevalence of tobacco, alcohol, and illicit drug use. Poor women have less access to prenatal care. Taken alone, none of these factors have been shown to be causative factors for preterm labor (Hoffman & Bakketeig, 1984). The combination of factors is probably more important than any one of the socioeconomic markers, and data are inadequate to implicate one factor as having a greater effect than the others.

Race is a factor in preterm labor, but the relationship is unclear. It has been postulated that race is a reflection of socioeconomic status and not an independent factor (Reedy, 2007). Kistka et al. (2007) found that recurrent preterm birth occurred more often in black women than in white women. Age under 16 and over 35 are associated with low maternal weight and poor weight gain with preterm labor (Cohen et al., 2001). However, nutritional interventions have not produced a reduction in the preterm birth rate in underweight women (Reedy, 2007).

The use of tobacco, alcohol, and illicit drugs has not been found to be a causative agent for preterm labor or preterm birth, but their use is implicated in preterm labor because of the effect on the fetal environment. The use of these substances creates situations of fetal jeopardy that lead to iatragenic prematurity. Smoking is known to place the fetus at risk for intrauterine growth restriction and oligohydramnios. Savitz, Dole, Terry, Ahou, and Thorp (2001) studied link smoking to an increased risk of premature prolonged rupture of membranes. Women who drink more than 9 or 10 drinks per week are at risk for preterm labor at all gestations (Kesmodel, Olsen, & Secher, 2000). A lower alcohol intake in the third trimester seems to result in a reduced risk of preterm birth (Kesmodel et al., 2000). Callhoun and Watson (1991) found that cocaine and methamphetamines are associated with an increased risk of acute maternal hypertension and associated placental hemorrhage that result in preterm birth for fetal indications.

Maternal stress has been studied in various ways. Heavy physical work, prolonged standing, and shift work have been associated with preterm labor (Mozurkewich, Luke, Avni, & Wolf, 2000). A more recent study by Pompeii et al. (2005) implicated work at night but did not find physically demanding work to be a

factor in preterm labor. Emotional stress and psychiatric disease have been proposed as factors but research is not clear. Women who have suffered physical abuse in the last 12 months are at greater risk for preterm labor (Cokkinides, Coker, Sanderson, Addy, & Bethea, 1999).

In conclusion, preterm labor is related to multiple risk factors included nonrecurring risk factors, recurrent or treatable factors, and recurrent but not treatable (London et al., 2003; Wold, 1997).

1. Nonrecurring risk factors: placenta previa, abruption placenta, hydramnios, second-trimester bleeding, and fetal anomaly or death.

2. Recurrent or treatable factors in the mother: genital tract infection, incompetent cervix, uterine malformation, uterine fibroids, low socioeconomic status, limited prenatal care, poor nutritional status, low prepregnancy weight, tobacco or drug use, occupation or work requirement, sexual activity, and anemia.

3. Recurrent but not treatable: history of preterm birth, race, and DES exposure.

Maternal implications of preterm labor include psychological stress related to the baby's condition and physiologic stress related to medical treatment for preterm labor. Fetal-neonatal implications include increased morbidity and mortality, especially due to respiratory distress syndrome, increased risk of trauma during birth, and maturational deficiencies.

Diagnosis of preterm labor

Women at risk of preterm labor are taught to recognize its symptoms, if any symptoms are present and they notify their certified nurse-midwifery or obstetricians immediately. Prompt diagnosis is necessary to stop preterm labor before

it progresses to the point at which intervention will be ineffective. Three tests are useful both in screening high-risk women and in helping confirm a diagnosis of preterm labor (Goldenberg, 2002; Newton, 2004):

1. Fetal fibronectin

Fetal fibronectin (fFN) is a protein normally found in the fetal membranes and deciduas. It is found in the cervicovaginal fluid in early pregnancy but is not usually present in significant quantities between 18 and 36 weeks' gestation. A positive fFN test if found fFN $\geq$ 50 ng/ml during this time puts the woman at increased risk for preterm birth within 1-2 weeks (Reedy, 2007). Conversely, a negative test is over 99% accurate for predicting no preterm birth within 7 days (London et al., 2003). The procedure for collecting a sample is similar to that of the Pap smear; results can be available within 1 hour.

2. Salivary estriol

Research indicates that maternal estriol level rise about 3 weeks before birth, either preterm or term (Newton, 2004; Wheeler, 1994). Estriol can be measured in the maternal blood or saliva, although saliva is preferred because it is a stable method and no venipuncture is necessary. Salivary estriol levels are most reliable in predicting preterm birth after 30 weeks' gestation (Goldenberg, 2002). The saliva sample should be collected during the day but not within 30 minutes of eating.

3. Transvaginal ultrasound

The length of the cervix can be measured fairly reliably after 16 weeks' gestation using an ultrasound probe inserted into the vagina. A cervix that is shorter than expected may be useful in assisting a physician to identify the need for a

cerclage to prevent preterm birth because of incompetent cervix. In general, cervical length less than 25 mm prior to term is abnormal (Newton, 2004; Reedy, 2007).

Diagnosis of preterm labor is confirmed if the pregnancy is between 20 and 37 weeks, and if there are uterine contractions (four in 20 minutes or six to eight in 1 hour), cervical change of 1 cm or more, cervical dilatation of more than 2 cm, or a positive fFN level (Goldenberg, 2002; Reedy, 2007). The most hospitals in Thailand, preterm labor are defined as onset of uterine contractions occurs during 28-37 weeks of gestational age.

Effect of preterm labor

The most common direct effect of preterm labor on a mother is psychological stress related to threats of a preterm delivery on the health and well-being of the expected baby. Other maternal consequences are related to the side effects of the medical treatment such as prolonged bed rest and the use of labor suppressant drugs on the mother's health. Fetal and neonatal effects, preterm labor leads to the delivery of an infant whose body processes are immature. Therefore, these infants have an increased risk of birth trauma and an increased difficulty adjusting to extra uterine life. Special problems seen in the preterm infant as follows: respiratory distress syndrome, intraventricular or pulmonary hemorrhage, hyperbilirubinemia, increased susceptibility to infections, anemia, neurological disorders, metabolic disturbances, and ineffective temperature regulatory mechanism (Draper et al., 1999; Goldenberg, 2002; Newton, 2004). The severity of problems depends greatly on the gestational age of the infant (Reedy, 2007).

Preterm labor may result in the mortality and morbidity of the mother and fetus or neonate. Pregnant women with preterm labor need clinical treatment and care

(Gilbert & Harmon, 1993). They feel stress and anxiety including concern for their illness and how the treatment may impact on fetal health. In recently times, medical technologies have advanced providing many therapeutic alternatives. Some treatment investigations are expensive and pregnant women may feel that physicians overuse such treatments. Although they may have conflict feelings, they could not ask the physicians because of a lack of knowledge or due to shyness (Klima, 2001).

Preterm labor not only impact on pregnant women's health but also impact on their families and their socio-economics aspects. Preterm babies need special care and life-long care from their families due to physical handicaps. The total cost for hospital newborn care in the United State is $35.7 billion annually (Goldenberg, 2002; Newton, 2004). Babies with the diagnosis of preterm birth use half of these resources: nearly $18.1 billion dollars a year (Reedy, 2007). Health care dollars today focus on "rescue and rehabilitation" of the preterm infant. Preterm babies are often the highest cost population for health care insurance companies (Jones et al., 2002). The medical and economic consequence of preterm delivery include five million hospital days per year at a cost of over five billion dollars, these figures do not include projected additional costs for rehospitalization, special education, and long-term and even custodial care for survivors with chronic illness or handicap (Murphy, 1993). Thus, the prevention of preterm birth may be the most important issue in maternity care.

Management of preterm labor

The goals of management of preterm labor with intact membranes include: (1) early assessment of risk for preterm birth, (2) diagnosis of preterm labor, (3) identifying the etiology of preterm labor, (4) documenting fetal well-being, (5) providing prophylactic fetal therapy, (6) making a thoughtful choice to initiate

tocolytic therapy, and (7) establishing a plan of surveillance and patient/ provider education for at-risk patients and after the initial therapy.

The goal of clinical therapy is to prevent the preterm birth of a compromised infant. Attempts to prevent labor are not indicated if one or more of the following conditions are present: severe preeclampsia or eclampsia, chorioamnionitis, hemorrhage, maternal cardiac disease, poorly controlled diabetes mellitus or thyrotoxicosis, severe abruption placenta, fetal anomalies incompatible with life, fetal death, acute fetal distress, or fetal maturity (Reedy, 2007).

The initial management of preterm labor is directed toward maintaining good uterine blood flow, detecting uterine contractions, and quieting the fetus (Goldenberg, 2002; Newton, 2004). The mother is asked to lie on her side to increase profusion, and an IV infusion is started to promote maternal hydration. Tocolysis is the use of medications in an attempt to stop labor. During the antenatal period, identify the woman at risk for preterm labor by noting the presence of predisposing factors. Nursing diagnosis that may apply to the woman with preterm labor include the following: fear related to risk of early labor and birth and ineffective individual coping related to need for constant attention to pregnancy. Supportive nursing care is important to the woman with preterm labor during hospitalization. It is important to promote bed rest, monitor vital signs, measure intake and output, monitor the fetal heart rate continuously, and monitor uterine contraction. Having the women lie on her left side facilitates maternal-fetal circulation (London et al., 2003). Keep vaginal examination to a minimum. If tocolytic agents are being administered, monitor the mother and fetus closely for any adverse effects. Whether preterm labor is arrested or proceeds, the woman and her partner, if he is involved, experience in tense

psychological stress. Provide emotional support to help decrease the anxiety associated with the risk of a preterm newborn (Reedy, 2007). Also recognize the stress of prolonged bed rest and lack of sexual contact and help the couple find satisfactory ways of dealing with those stresses (Moore et al., 2004).

Prevention of preterm labor

The ultimate goal of prevention and treatment of preterm labor is delivery of a healthy term infant. It is a fact that neonatal outcomes are greatly improved when intrauterine life can be extended until fetal lungs are mature. It is therefore suggested that delaying labor for even a few days can be beneficial. Screening and education are the key factors to prevent preterm labor. Early diagnosis and frequent health care contact can have a positive effect on early treatment of preterm labor before advanced cervical changed take place. Prenatal nurse-midwives can have a positive impact on neonatal morbidity by doing what nurse-midwives do so uniquely well. Screening, motivating, providing health care education, and frequent caring and sensitive contact with at-risk pregnant women can make a significant contribution to lowering neonatal morbidity and mortality (Reedy, 2007).

Patient participation

Patient participation in care delivery is a broad and complex concept with no universal definition in either the nursing or the medical literature (Jewell, 1994). Webster's dictionary (1994 cited in Epstein, Alper, & Quill, 2004) defines the verb "participate" as "to engage or have a share in common with others". Biley (1992) stated that patient participation means active patient behavior by asking questions,

seeking explanations, stating preferences, offering opinions and expecting to be heard. Frequently, participation seems to be automatically included in decision-making activities. The patient can participate in medical treatment decisions and in decision concerning nursing care (Waterworth & Luker, 1990). The term 'patient participation' has been used interchangeably with patient involvement, partnership and patient collaboration (Brearley, 1990; Jewell, 1994) Thus, participation means getting involved or being allowed to become involved in a decision-making process or the delivery of a service or the evaluation of a service, or even simply to become one of a number of people consulted on an issue or matter. The significance, influencing factors, and level of participation are presented as below.

Significance of patient participation

The philosophical foundations underpinning patient participation are related to freedom of choice, autonomy, dignity, and liberty. Patients were perceived to have certain rights including dignity, respect as human beings, autonomy, choice and control over different aspects of their lives such as their health encounter with nursing services. Autonomy has been described as an outcome of empowerment because it has the ability to produce independent thinking and action (Ballou, 1998). Empowerment may lead to autonomy when there is sharing of responsibility and authority (Gibson, 1991).

Respect for human dignity is another ethical foundation for treating others as persons. Respect requires understanding, knowledge, and trust that many human beings are able to comprehend and act appropriately most of time. Respect should be freely given, from one human being to another. Klima (2001) stated that respect implies that both midwife and the woman she is caring for are equal when it comes to

the ‘humanness’ and basic human rights. Peplau (1988) and Cahill (1998) also revealed that patient participation as a psycho-social skill was facilitated by a nurse who accepted and respected the patient as a person who could make choice. In addition, Beaver et al. (1996) stated that patient participation is a collaborative process which involves patient empowerment. Patients are regarded as being capable of making suggestions and capable of making decisions. Nurses provide the patient with a ‘voice’, or the opportunity to have a say in what is happening (Waterworth & Luker, 1990). Jewell (1994) identified that patients needed to be central to decisions which affect their health and well-being. The patient should be invited to become an active collaborator rather than a passive receiver. Therefore, the fundamental roots of participation are based on assumptions about collaboration.

Patients are individuals who have the right to be involved in making informed choice about themselves and their future. Patient autonomy defined as the freedom to make decisions within the limits of competence of the individual (Pearson, Vaughan, & Fitzgerald, 1996). The opposite of autonomy is to comply with the dictates of people who are in a superior position. All patients should have the freedom to identify their own needs, and to decide how these needs should be met. For example, sick people being cared for by nurses should be given the power to make their own decisions about how they will be nursed. It may entail either selecting particular ways of carrying out a daily living activity or choosing to give the responsibility for the decisions to the nurse because patients feel unwell and are unable to decide. Sainio et al. (2001) stated that participation involves equalizing external and internal demands which mean that patients themselves choose what would be the best for themselves, even if it is not the popular alternative sanctioned

by society's norms. The consequence of a participated decision is a free choice with or without an associated intentional action.

The concept of patient participation in their own health care has been of great theoretical interest to the health professions, particularly in western countries (Chunuan, Vanaleesin, Morkruengsai, & Thitimapong, 2007). Previously, patients relied upon the health care providers, but in the last three decades it has become more common for patients to seek active participation in decision-making processes affecting their care (Biley, 1992). Recently, there has been a tremendous rise in public consciousness concerning patients' rights related to participation in their health care. The promotion of patient participation is based on the belief that patients have a right and a responsibility to be involved in their health care process. Thus, opportunities to participate in health care services have increased from about the 1970s to the present (Chunuan et al., 2007).

Ashworth et al. (1992) declared that proper patient participation entails awareness and empathy for the patient. Patient participation involves the nurses attempt to give patients greater choice, to promote activity in care to a degree which accords with the individual's negotiated needs.

Level of patient participation

Several classifications used to categorize the extent of patient participation. The participation has ranged from non-existent to moderate or to full participation or even veto-participation (Cahill, 1996). Klein (1974 cited in Biley, 1992) also developed five distinct and specific classifications of patient participation as follows:

1. Information: the physician actively gives information and the patient passively receives it.
2. Consultation: the physician may consult the patient and may use the information gained.
3. Negotiation: a greater degree of equality exists and the possibility of a bargaining situation arises.
4. Participation: both parties take part in the decision-making process.
5. Veto-participation: the patient holds the right to block all treatment decisions.

In addition, Cockerham (1994) stated that there were three models related to doctor-patient interaction. Firstly, the activity-passivity model, this applies when the patient is seriously ill or being treated on an emergency basis and is in a state of relative helplessness. Decision-making and power in the relationship are all on the side of the doctor, as the patient is passive and contributes little or nothing to the interaction. Secondly, the guidance-cooperation model, the doctor makes the decisions and the patient acts as instructed. Thirdly, the mutual participation model, the patient works with the doctor as a full participant in treating a health problem. In the mutual participation model, the patient asks questions, seek full explanations and makes rational choices as an informed consumer about the medical services offered by the doctor.

There are evidences supporting participatory clinical decision-making which is viewed as a process (Beave, Luker, Owens, Leinster, & Degner, 1996; Bottorff et al., 2000; Cahill, 1996; Glenister, 1994; Jewell, 1994; Neufeld et al., 1993; Saunder, 1995). For example, Saunder (1995) confirms that patient participation is an

active process, as he advocated that it involves patients performing clinical or daily living skills, or partaking in the decision-making process from the time of admission to discharge. Nurses' efforts to support patients' participation in decision-making were described as a four-phase process: getting to know the patient, enhancing opportunities for choice, being open to patient choice, and respecting choice (Bottorff et al., 2000).

Cahill (1996) stated that the consequences of patient participation is increased capability of self care, enhanced patient empowerment, heightened satisfaction with health care services, better patient adjustment, greater acceptance of outcome of decision-making, improvement in the health care provider-patient relationship, and enrichment in the quality of life. Several other studies found that patient participation in decision-making has beneficial outcomes (Ashworth et al., 1992; Clayton, 1988; Dennis, 1987; England & Evans, 1992) such as enhanced self-esteem and sense of control, and increases responsibility for one's own health, self-care, and satisfaction with the health services. The results of these studies were supported by Brody (1980) who found that increased patient participation improved the quality and outcome of care. In addition, there is evidence that patient participation also influences the results of decision-making (Macleod, & Webb, 1985) and satisfaction with the outcome (Lott et al., 1992; Suominen, 1992). The advantages might directly benefit the patient, physician, and physician-patient relationship. Increased patient participation in clinical decision-making enhances the doctor-patient relationship in several ways (Henderson, 2003). The tendency of physicians to view their patients as objects to be manipulated is diminished. As physicians gain increased awareness of their patients' needs, desires, values, and preferences, they are

able to provide more satisfactory care. Waterworth and Luker (1990) found that the outcome of participatory clinical decision-making process represents free choice. In addition, patients participate in their own care seems to be an important factor in expediting the rate of recovery from surgery (Hanuchareankul & Vinya-nguag, 1991). Participation in clinical decision-making may lead to increase satisfaction with the decision and consequently to better compliance and better health outcome (Brody, 1980; Sainio et al., 2001). Furthermore, it may enhance patients' self-esteem and increase clinicians' awareness of patients' expectations and preferences (Rudman et al., 2007; Sainio & Lauri, 2003).

Participation in decision-making

Decision making is the cognitive process of selecting a course of action among multiple alternatives. Pierce (1993) described that decision making is a psychological construct. It means that although we can never "see" a decision, we can infer from observable behavior that a decision has been made. Therefore, it could be concluded that a psychological event called "decision making" has occurred. It is a construction that imputes commitment to act. That is, based on observable actions; it is assumed that people have made a commitment to effect the action.

The philosophical foundation underpinning decision-making is the belief that a human is a rational being that has the liberty to think, to give reason, to make choice, and to act. Pierce and Hicks (2001) defined autonomy as "the freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions" (p. 268). Ballou (1998) also identified that decision-making is a central theme in the concept of autonomy. There are two dimensions of decision-making as an attribute of autonomy. One is that a person has

the freedom to choose how best to achieve or satisfy a preference. The other is that an individual has the freedom to act on his choices. Henderson (2003) stated that the autonomous person is capable of making rational and unconstrained decisions and acting on those decisions. Active participation by patients is used synonymously with decision-making and intentional action. In addition, Pierce and Hicks (2001) stated that self-management through active participation of the patient relinquishes control by health care professionals and allows patients to act on their own behalf.

Pregnant women with preterm labor are rational beings and having the capability to make choice in clinical care or treatment. Therefore, health care providers should encourage them to participate in clinical decision-making.

Factors influencing participation in decision-making

Relevant research on participatory clinical decision-making comes primarily from Western literature, as Thailand had few studies concerning the perceptions and experience of patient participation in decision-making. In Western countries, freedom of choice and patient rights are increasingly being emphasized in modern health policy and in legislation (Pelkonen et al., 1998). Derived from her concept analysis, Cahill (1996) proposed that the predictors of patient participation included an egalitarian communication system, respect of individuality, healthcare provider relationship, appropriate information and knowledge, authority and attitude of health providers.

In Thailand, as in other Southeast Asian countries, most women do not participate in their health care; despite they perceive several benefits of patient

participation (Wilcock, Kobayashi, & Murray, 1997). A number of studies related to childbirth have shown that a patient's participation in their own care is associated with the patient's satisfaction with the care given (Blix-Lindstrom, Christensson, & Johansson, 2004; Guadagnoli & Ward, 1998; Holmes-Rovner, et al., 2000; Sainio, Eriksson, & Lauri, 2001). Health care providers should encourage patients to get involved in their care. However, several factors are related to patient participation in their health care. Existing research related to this study concerning factors influencing participatory clinical decision-making including patients' demographic characteristics, health care provider- patient relationships, patient knowledge/information/ experience, and health care system (Pelkonen et al., 1998; Thompson, 2002).

Patients' demographic characteristics

Several studies have found that the patients' demographic characteristics, correlate with their participation in decision-making (Biley 1992; Degner & Sloan, 1992; Sainio & Lauri, 2003; Thompson et al., 1993) According to patients' demographic characteristics, i.e. age, education level, gender, marital status, patient condition, and cultural background (Sainio & Lauri, 2003; Thompson, Pitts, & Schwankovsky, 1993, Trnobranski, 1994).

Age shows a particularly strong association with patient participation in decision-making. Cahill (1998) revealed that younger patients that preferring a more active role than older patients because the younger patients were the more satisfied with the information than the older patients. Stiggelbout and Kiebert (1997) also found that older patients were more likely to let the physician make decisions regarding their treatment. They are more willing to gather information and to use it in

the decision process. The findings were congruent with the study of Kirk and Glendinning (1998). They also found that the majority of patients wanted to play an active role in decision-making but that this more restricted to younger, more highly educated people, whereas older patients had particular difficulties in making decisions about their treatments.

Educational level is influencing the patient participation in decision-making. The better educated patients participate more or wish to participate more in decision-making because they had been able to discuss the options and their consequences in situations requiring decision-making better than the lower education (Hughes, 1993; Degner & Sloan, 1992). Beaver et al. (2005) stated that the active or sharing roles in treatment decision making with younger women, women with higher educational levels and those with earlier stage disease more likely to prefer active involvement.

According to gender, Degner and Sloan (1992), Hughes (1993) and Stiggelbout and Kiebert (1997) revealed that men wanted to participate in clinical decision-making more than women. Nevertheless, Sainio and Lauri (2003) found that women regarded participation in decision-making about treatment and nursing care as more important than men did. They found that women patients had a good relationship with staff members, they participated more in decision about treatment and nursing care than when they felt the relationship was not so good.

Marital status is influencing factor of patient participation in decision-making. Degner and Sloan (1992) found that married patients preferred a more passive role in the decision-making process. The single patients felt that their self-

confidence to participate in decision-making was better enhanced than the married patients (Pelkonen et al., 1998).

Patient's condition is also influencing factor of patient participation in decision-making. Faces with life-threatening diseases, patients seem to prefer a more passive role (Ende, Kazis, Ash, & Moskowitz, 1989). Differences have been found between patients with cancer and the general public, with patients displaying a stronger wish to leave decisions to the physician (Degner & Sloan, 1992). In addition, progression of disease may be associated with a decrease wish for participation (Catalan et al., 1994). Stiggelbout and Kiebert (1997) suggested that the "sick role" influences the preference regarding participation more strongly than the type of decision to be made or the presence of a life-threatening disease. This hypothesized shift in preference among persons who are sick implies that these patients need encouragement to participate (Stiggelbout & Kiebert, 1997). In addition, Biley (1992) revealed that patients in poor condition were less likely to participate because they could not gain the information that is the key factor of participation in decision-making. Sainio and Lauri (2003) also stated that patients who had high dependency needs or perceived their situation as a matter of fate, participated less in decision-making.

According to cultural dimension, woman in Thai culture is a factor that influenced on patient participation in decision-making. Cultural belief and norms largely determine much of shared experiences in life. Thai social structure influences Thais, determines social and family relationships, and shapes attitudes toward illness (Klausner, 1997). Thus, concepts of Thai social hierarchy, gender role, and Buddhist worldview in the Thai culture are elaborated below.

Thai social system is mainly hierarchical, thus social standings and responsibilities are specifically ranked based on social status, seniority, wealth, and power (Klausner, 1997; Suvanajata, 1976). Most of the social hierarchy is expressed through a super ordinate-subordinate relationship (Podhisita, 1998). For example, traditionally, a husband is the leader, supporter, and protector of his wife. The wife is expected to respect, comply, obey, and honor her husband (Boonmongkol, 2000; Suphametaporn, 1999). In addition to social status, gender roles are also socially constructed and clearly defined in Thai society. Women are always subordinate to men (Bandhumedha, 1998). A "good woman" must be passive, quiet, obedient, and patient in accordance with her lower gender role (Suphametaporn, 1999); especially in the study most obstetricians are men. Some pregnant women may be shy to talk to male obstetricians about some problems. Thus, they would remain quiet reluctant to participate in clinical decision-making.

Generally, pregnant women with complications have been oppressed; resulting in difficulty of them making their own decisions about the treatment (Wittmann-Price, 2004). This is especially true, in Thai culture. Because women have been traditionally considered to be quite inferior (Boonmongkol, 2000), modern medicine still does not provide patients with the opportunity of participation in clinical care. The gap between Thai pregnant women with preterm labor and nurses or other health care providers regarding participatory clinical decision-making is still quite wide. Thus, it is useful to explore the process of participatory clinical decision-making in order to understand the phenomenon and as a consequence, to develop guidance for health care providers to encourage pregnant women with preterm labor to participate in clinical decision-making.

Another important factor is the Buddhist worldview that teaches that life is part of nature, and therefore, no one can escape the "natural laws" of suffering, sickness and death (Klausner, 1997). The Thai people's view of health and illness is influenced by Buddhist belief that things and events are beyond individual control and that nothing can be done to prevent or escape from them. Consequently, Thai people are more likely to accept illness or unpleasant experiences as the product of their own "fate" (Podhisita, 1998). Thus, they would accept the physicians without negotiated power. Giving due respect to the physicians, patients are not likely to reject their suggestions but would tend to follow their physicians judgments even if they have inner conflict.

Health care provider- patient relationships

Health care provider- patient relationship is at the heart of the caring relationship. In nursing practice, nurse-midwives should emphasis on more open and collaborative relationship with patients (Hewison, 1995). The shift to new pattern of care has required a more complex set of interactions and interpersonal relations than were the case in a routinized and task-oriented operational setting. In particular, it has relied on the development of ideas about a reciprocal relationship between nurse and patient (May, 1995). Morse (1992) identified four types of nurse-patient relationships: clinical relationships, therapeutic nurse-patient relationships, connected relationships, and over-involved relationships. In particular, the connected relationship is characterized by qualities, such as openness, self-disclosure, trust, and friendliness. It is a connected relationship because the nurse perceives the person in the consumer first before perceiving the consumer in the person. The reciprocal nature of the relationship between nurses and consumers has been emphasized, because the

behavior and expressions of each affect both (Jewell, 1994). This type of relationship between consumers and nurses has been described as a partnership (McCann & Baker, 2001).

Several studies found that a major factor affecting participatory decision-making is the relationship between patient and staff members (Bottorff et al., 2000; Henderson, 2003; Holmes-Rovner et al., 2000; McQueen, 2000; Pierce & Hicks, 2001; Sainio et al., 2001). The most obvious issue is the balance of power and control (Tronobranski, 1994). The first requirement of patient participation is open and equal relationships with the patients who do not have to fear the medical staff (McQueen, 2000). Moreover, Laitinen and Isola (1996) stated that a warm, friendly atmosphere and trustful relationships in interactions with patients made it easier for patients to co-operate with nursing staffs. Lack of communication among relatives, staffs and nurses, the traditional way of interaction with informal caregivers, inhibited participation in care.

Lott et al. (1992) showed that patients had numerous problems with communication, i.e. they did not understand the information they receive and they reported problems when asking questions and expressing feelings to the staff. Staffs attitudes and skills are also important in influencing participatory decision-making (England & Evan, 1992; Elwyn, Edwards, Gwyn, & Grol, 1999). It is impossible for patients to participate in decision-making if health care providers are against them, or if they do not have required skills that involve patients in decisions (Elwyn et al., 1999).

According to patient and health care provider relationships in Thailand, health professions are respected because their roles give them responsibility for

helping clients to improve their health and be healthy. In rural areas, people strongly respect their health care providers. Health care providers are part of their community because they are involved in various activities in the rural society. Some rural people respect community nurses in the same way that they respect physicians because community nurses are seem to have similar roles as they provide basic medical treatment, administer children's vaccines, visit sick people, and promote the people's health. Rural people may also call community nurse by name such as *Khun Mho*; which means physician. On the other hand, in urban areas, the relationship between health care provider and patient is not as close as in rural areas. They are different from rural areas because the ratio of physicians to patient is very high. The interaction between health care provider and patient is normally somewhat formal, and they do not share common interests with patients such as social activities. However, urban patients also respect and depend on their health care providers. For example, malpractice suits are quite rare in Thai society. Indeed, Thai health care providers do not buy or use practice insurance. When malpractice or an error in medical intervention does occur, most hospitals and professional institutions take responsibility and help all health care providers to deal with their problems (Chunuan et al., 2007).

If trust is developed in the patient-health care provider relationship, both the health care provider and patient will feel free to share concerns and information, resulting in a true health care partnership (Linda, 1997). Beaver et al. (2005) also stated that trust in medical expertise was an important factor and should not be underestimated in terms of patient's satisfaction with their level of involvement. Most

patients appeared satisfied with their level of involvement based on trust in medical expertise.

Klima (2001) stated that the partnership model of nurse-midwifery care respects the woman as a person with autonomy, capability, intelligence. Instead of assuming that the woman knows little about pregnancy and is unwilling to participate in decisions about her health care, the nurse-midwife should take time to provide information, support the woman's efforts in taking responsibility for her own health, and works for the healthy mother and baby (Thompson, 2002). Proctor (1998) also stated that the patient-health care provider relationship there is two key issues: were being listened to and being respected.

Moreover, May (1995) revealed that 1) nurses spend little time in verbal communication with patients and that when interaction does occur, it was superficial and task oriented, 2) nurses use a range of tactics to avoid communication, and 3) nurses attempt to control all interaction in order to limit the quality and depth of verbal communication with patients.

Patient knowledge/ information/ experience

Several studies have found that the patients' experience, knowledge of and information about diseases and their effects are influencing factor of patient participation in decision-making (Guadagnoli & Ward, 1998; Pelkonen et al., 1998; Stower, 1992; Thompson et al., 1993). The sufficient information is a prerequisite for participating in decision-making. (Pelkonen et al., 1998; Stower, 1992; Thompson et al., 1993). Sainio and Lauri (2003) stated that patient desire to participate in decision-making depends on a number of factors, but the key factor is information. In the absence of adequate information it is impossible for patients to take a meaningful part

in decision-making and participation is not meaningful to them. Beaver et al. (2005) revealed that barrier to involvement in decision making related to a lack of information and inadequate medical knowledge among patients. The provision of information is an area that can be addressed and interventions have demonstrated that participation and/or involvement in health care decision making can be increased with appropriate intervention strategies. Lack of medical knowledge is difficult to address.

Holmes-Rovner et al. (2000) found that evidence based health care should be accompanied by evidence based patient choice, defined as offering patients information about treatment alternatives, the benefits and harms of each, and offering patients a key role in decision-making. Linda (1997) also claimed that access to health information is an essential component of women's viewpoint of health care. Health care providers should not only share health information but also assess their patients' understanding of the information and the role they wish their health care provider to play in the health care relationship. It can be accomplished if health care providers begin with their patients' perceptions, belief, and understanding of their health or illness. In addition, the sharing of power and information in the health care relationship can lead to the empowerment of patients who have the ability to be active participation in their own health care decisions (Linda, 1997).

Barry and Henderson (1996) also found that with the lack of adequate information, it is impossible for patients to participate in decisions and provision of care. There is an abundance of research evidence suggesting that information has a positive influence on patient's participation in decision-making (Barry & Henderson, 1996; Biley, 1992; Hughes, 1993; Sainio & Lauri, 2003; Sutherland et al., 1989). The

more patients receive information, the more they will participate or want to participate in decision-making (Sainio et al., 2001).

Health care system

Recently, patient participation in clinical decision-making has become an important issue because patients are viewed as consumers of the health care system who are requesting to make a choice in respect to their own health care. An increasing freedom of choice and patients' rights are being emphasized in modern health policy and in the legislation of many countries (Pelkonen et al., 1998). Patients in many countries have been encouraged to participate in clinical decision-making by bringing the issue of patients' rights into the public arena (Beaver et al., 1996). For example, in the United Kingdom, focusing on the patient as a consumer has been promoted through a Government White Paper, which endeavors to promote individual responsibility and self-determination as a hall-mark of consumerism (Trnobranski, 1994). In Australia, the initiative of promoting patient participation in the decision-making process is based on two premises, i.e., patients have the right to participate in their own health care, and the patients' quality of life is much improved when they are able to assist in determining their own future (Barry & Henderson, 1996). In Finland, the patient bill of rights has strengthened the self-determination of patients in their health care (Pelkonen et al., 1998). In Thailand, the Ninth National Health Development Plan also emphasized health promotion by encouraging people to participate in decision-making of their own health care (Ministry of Public Health Board, 2002).

Basically most Thai women believed that a good outcome will occur if they relied on the hierarchically organized health care system. This was based on the

assumption that caregivers' professional knowledge and technologic expertise were superior to the women's own knowledge of childbirth care (Chunuan et al., 2007).

In conclusion, patients' demographic characteristics, good relationships between health care provider and patient, patient knowledge/ information/ experience regarding health care, and health care system that encourage patient to participate in their health care were the factors that influenced on participation in decision-making.

Participatory clinical decision-making process among pregnant women

Participatory clinical decision-making process is rational being and having the capability to make choice in clinical treatment and care. Pregnant women with preterm labor are the high risk group that needs to receive clinical treatment and care from the health care provider. The clinical treatment and care are needed the clients to participate for enhancing their responsibilities of their self-care. The participatory clinical decision-making process will occur in an open atmosphere in which the health care provider and pregnant woman have a good relation. The pregnant woman needs the information that is used to take part in making decisions. Thus, health care provider needs to provide the information for the pregnant women in order to encourage them to participate in decision-making.

The active participation of patients in care decision-making requires an environment that encourages pregnant women to participate in their care. That kind of environment can only be created in the presence of adequate personnel resources, positive attitudes on the part of staff members and support from management. It is also important to make pregnant women aware of the possibility to participate in

decision-making. Although pregnant women do not always want to make decisions on their medical treatment many of them feel it is important that they have the opportunity to take part in discussions about their care and treatment. It needs to be borne in mind that participation in decision-making is not only about making medical decisions; very often it is also about even quite minor decisions about everyday nursing situations. A closer understanding of the pregnant women's point of view in particular is crucial to improve patient participation in decision-making.

Levy (1999) conducted a grounded theory study of the processes involved when women made informed choices during pregnancy. She found that the core category of the processes involved when women made informed choices during pregnancy was "maintaining equilibrium". When making informed choices during pregnancy, women were concerned with maintaining the equilibrium of themselves and their families. Three substantive categories emerged within the core category: "regulating", "contextualizing", and "actioning". Regulating information which concerned the woman included avoiding the pursuit of information, delaying the pursuit of information, and pursuing information. When contextualizing information, the women legitimated the information and personalized it in terms of its value and applicability to themselves. In the actioning category, women pursued various strategies, i.e., asserting, playing the game, taking it as it comes, and handing over. The pregnant women appreciated nurse-midwives who were trustworthy, supportive, and genuinely concerned in helping them make real choices.

Generally, pregnant women with complications have been oppressed; resulting in difficulty of them making their own decision about the treatment (Wittmann-Price 2004). This is especially true, in Thai culture. Because women have been traditionally

considered to be quite inferior (Boonmongkol, 2000), modern medicine still does not provide patients with the opportunity of participation in clinical care. The gap between Thai pregnant women with complication and nurse-midwives or other health care providers regarding participatory clinical decision-making is still quite wide. Thus, it is useful to explore the process of participatory clinical decision-making in order to understand the phenomenon and as a consequence, to develop guidance for health care providers to encourage pregnant women with preterm labor to participate in clinical decision-making.

Feminist theory

Epistemological views about women may differ in various feminist theoretical approaches, but all concentrate on the oppression of women, regardless of its origin, and advocate methods for change, whether individually or collectively. Regardless of its origin, power over women causes oppression and denies equality or 'voice' (Arslanian-Engoren, 2001). The main concepts of feminist theory substantiate the premise of oppression as a constant phenomenon that penetrates decision-making in women's health care. Nursing feminist theorists propose equal rights, equal treatment and caring as basic values (Klima, 2001). Feminism is defined as 'a world view that values women and that confronts systematic injustices based on gender' (Chinn & Wheeler, 1985; p. 74). Feminism provides a way of viewing women from the context of their own experiences; it is not only feminism's influence on women that is paramount, but women's influence on feminism. The women's experience, vision, women's knowledge, and ways of knowing have shaped feminism. The same

knowledge is used by nurses who are mostly women. Knowledge forms the theories that influence practice (Klima, 2001). Women have many different ways of knowing; they are not a homogeneous group. A women's world view can be influenced by her history and such differences as social class and ethnicity as well as economical and political factors which affect her values, beliefs and experiences. These inherent differences between women which influence their experiences, knowledge, and thinking are addressed by feminism.

Feminism has caused nurses to question their roles, stimulated research, and resulting in development of nursing theory that has influenced nursing practice and initiated change in the involvement of decision-making and gaining greater autonomy. Consequently, a positive influence on the rights and roles of women and health care can be attributed to the feminism movement leading eventually to enhance empowerment. Linda (1997) stated that the feminist model of practice is grounded in feminist theories that are applicable to the health and health care of women. The goal of the model is to change how health care is delivered to individual women, but also to seek social transformation. Four major themes recur in the model: symmetry in provider-patient relationships, access to information, shared decision-making and social change. Linda (1997) also claimed that access to health information is an essential component of a feminist viewpoint of health care. Providers should not only share health information but also assess their patients' understanding of the information and the role they wish their provider to play in the health care relationship. It can be accomplished if providers begin with their patients' perceptions, belief, and understanding of their health or illness. In addition, the sharing of power and information in the health care relationship can lead to the

empowerment of patients who have the ability to be active participants in their own health care decisions. If trust is developed in the patient-health care provider relationship, both the provider and patient will feel free to share concerns and information, resulting in a true health care partnership.

A feminist approach encourages the provider to strive for change in the large social structure at large (Arslanian-Engoren, 2001). Striving to maintain freedom, illuminating the effects of poverty and race on the health of woman, ensuring that women have a choice in their childbirth providers and place of birth, and assisting women to gain a voice in their personal, economic, and political lives are ways that nurse-midwives have worked to improve the status of women.

Although there is a growing body of research in the area of participatory clinical decision-making of the pregnant women in Western countries, little is known about participatory clinical decision-making experiences of Thai pregnant women with preterm labor. The majority of studies regarding Thai pregnant women have focused on Western concepts through utilizing instruments developed overseas or questionnaires based on Western literature. It seems likely that the results, which are measured from these instrument, may be distorted and biased and may not be applicable to prenatal care required by Thai women. There is a great need for qualitative research to provide the grounding and understanding of participatory clinical decision-making of Thai pregnant women with preterm labor during pregnancy. Nurse-midwives and other health care providers would be able to improve the quality and effectiveness of prenatal care to Thai pregnant women with preterm labor. Moreover, it is appropriate to use a grounded theory approach in the study because grounded theory approach is used to explore the social process that presents

itself within human interaction (Streubert & Carpenter, 2003). The methodological framework of grounded theory is thus presented below.

The grounded theory method was considered to be appropriate for this study as it can explore the participatory clinical decision-making of Thai pregnant women with preterm labor including their perceptions and interactions. Moreover, this approach can uncover the meanings of experiences that Thai pregnant women with complications perceive and the way in which they interpret them. The purpose of the grounded theory is to describe the stages and processes of a particular experience (Chenitz & Swanson, 1986; Morse & Field, 1996; Schreiber & Stern, 2001). As the participatory clinical decision-making is a process entailing change over time, the grounded theory is suitable to explore participatory clinical decision-making of Thai pregnant women with preterm labor. A detail of grounded theory is presented.

Grounded theory methodology

Grounded theory methodology is considered suitable when investigating human behaviors in which the relevant variables have not been clarified (Schreiber & Stern, 2001; Stern, 1980). Furthermore, the grounded theory method through a symbolic interactionist view offers a systematic way to study human behaviors through interactions within their social life (Blumer, 1969, p.3). The philosophical and theoretical perspectives underpinning grounded theory methodology along with grounded theory procedures are described.

Philosophical and theoretical perspectives

Grounded theory methodology was originally developed by Barney Glaser and Anselm Strauss in the early 1960s (Glaser & Strauss, 1967). Grounded theorists believe that there is a socially constructed reality and that truth emerges from the interpretation and analysis (Strauss & Corbin, 1998). Strauss (1987) suggested that theory must be grounded in the reality of lived experiences. Grounded theory was developed with the inspiration from philosophical and sociological paradigms of American Pragmatism and Symbolic Interactionism (Glaser & Strauss, 1967).

Symbolic interactionism is a theory of human action and a way to study human group life from the sociological viewpoint (Strauss, 1987). This approach was primarily derived from an intention to understand social interaction, social processes, and social changes by way of understanding the actor's views. Blumer (1969) developed the symbolic interactionist approach based on the work of George Herbert Mead by articulating that individuals are active participants who create meaning from the symbols around them through interactions among each other. It is a researcher's aim to explore the symbolic meanings, objects, signs, situations, and words people have as they interact within their group life (Cutcliffe, 2000). Chenitz and Swanson (1986) stressed that the importance of symbolic interactionism and noted that it is helpful in conceptualizing behavior in complicated situations and understanding the influences of new ideologies. Additionally, it is particularly useful for health care personnel when the interaction with the health care system is a factor affecting the way patients manage their health care problem.

Symbolic interactionists regard meanings of the things for human as originating from the process of interaction between humans. Meaning of the things is

neither merely an intrinsic makeup nor personal psychological expression. Humans point out to themselves the things that have meaning for them through a process of "self-interaction" in which an individual interacts and communicates with oneself to assign meaning (Blumer, 1969, p.5). The meanings set the way that the physical, social, or abstract objects are perceived, talked about, and acted toward (Berger & Luckmann, 1967). Since meaning is created through the self, by disclosure to new experiences individual creates new self-definition and change behavior (Chenitz & Swanson, 1986).

Symbolic interactionists believe that human beings indicate or refer to things as they see them from their perspective (Blumer, 1969, p.27). From this point of view, it is necessary for researcher who employs symbolic interactionism methods to explore the situation from the actor's perception, investigate what the actor's take into account in the situation, and describe how the actor interprets the situation which results in particular actions. Chenitz and Swanson (1986) suggested that in order to achieve this, the researcher must "take the role of other" by being both a participant and a bystander of the world (p.7). It is in the this way that researchers can come to know about their inquiry by having their data and interpretation emerge from and remain grounded in the empirical life of people under study (Denzin, 1992). The tenet of symbolic interactionism to seek explanatory theories that are interpreted, grounded, and emergent from the data has contributed profoundly to the methodology of grounded theory.

Grounded theory procedures

The grounded theory method has been described as "a qualitative research method that uses a systematic set of procedures to develop an inductively derived

grounded theory about a phenomenon" (Strauss & Corbin, 1990, p.24). In this method the emergent theory is closely related to data collection and data analysis process. Researchers allow the theory to emerge from data. Therefore, researchers generally start an inquiry without a pre-set hypothesis in mind (Strauss & Corbin, 1998). Cuteliffe (2000) suggested that preoccupation with previous theory may influence researcher's attempt to hear and listen to what being said in the study.

Strauss (1987) described some distinct characteristics of grounded theory methodology that include theoretical sampling, constant comparative analysis, and the use of the coding paradigm to ensure conceptual development and density. Grounded theory methodology involves all reasoning techniques including induction, deduction, and verification. The theory induced from the grounded theory procedure is conceptually dense, which refers to the richness of concept development and conceptual relationships embedded in great familiarity with, and repeated checking of associated data. Therefore, grounded theory must be traceable to the data that gave rise to them.

In order to include study participants who reflect specific data sources that allow for concepts and categories to emerge and be fully understood, grounded theory uses theoretical sampling. Glaser and Strauss (1967) stated that in the early stages of theoretical sampling, decisions for data collection are made on the basis of a general sociological view and a general problem area. Hence, in the initial step of a grounded theory study the researcher draws a purposeful sample by selecting participants with a broad knowledge about the phenomena, as codes emerge theoretical sampling is applied.

The theoretical sampling is “a process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his or her data and decides what data to collect next and where to find them, in order to develop the theory as it emerges” (Glaser & Strauss, 1967, p.45). This process guides a full saturation of the codes by a use of comparative examples. The theoretical sampling process can be accomplished by asking analytical questions of the data and the participants to expand an understanding of the categories (Jezewski, 1995). The theoretical sampling is used until each category reaches theoretical saturation that is indicated by the dense description of the category occurring along with variation and process, by having no new data added into the category, and by finding that the relationship between categories are integrated and validated (Strauss & Corbin, 1990).

Constant comparative analysis is another important feature of grounded theory procedure. In this analytical technique, the similarities and differences of the categories and events are compared with previously collected data to help the researchers attain a greater precision and consistency of when similar or like incidents are grouped together (Strauss & Corbin, 1990). This constant comparative method provides a verification of emerging theory throughout the course of a study by constantly redesigning and reintegrating theoretical concepts as data are revealed (Glaser & Strauss, 1967). There are four stages of constant comparative analysis including: comparing incidents applicable to each category, integrating conceptual categories and their properties, delimiting the theory, and writing the theory. Although, these processes are implemented sequentially from the earlier to the next stage, a researcher keeps doing the earlier stages of analysis while performing the later analysis process until the analysis is finished (Glaser & Strauss, 1967)

In conclusion, the evidence from literature review found that respects the pregnant woman as a person with autonomy, capability, intelligence. Instead of assuming that the woman knows little about pregnancy and is unwilling to participate in decisions about her health care, the nurse midwives should take time to provide information, support the pregnant woman's efforts in taking responsibility for her own health, and works for the healthy mother and baby. In addition to social status, gender roles are also socially constructed and clearly defined in Thai society. Women are always subordinate to men. Evidence reveals the gap of knowledge regarding participate in clinical decision-making process of pregnant Thai women with preterm labor. In order to understand this process and guidelines to care for pregnant women with preterm labor, the literature suggests that a study through pregnant women's experience is the way to direct change in the social structure.

CHAPTER 3

METHODOLOGY

This chapter provides a description of research methodology used in this study including research design, participants and settings, instruments, data collection, protection of human subjects, data analysis, and trustworthiness.

The study was designed to explore the process of participatory clinical decision-making among pregnant Thai women with preterm labor. Grounded theory was selected as the method for this study. The research design is emergent and is comprised of the analytic components of theoretical sampling, intensive interviewing, and inductive analysis using the constant comparative method (Strauss & Corbin, 1998). These components are performed concurrently throughout the research process until theoretical saturation is achieved and the grounded theory is generated. The grounded theory method enables the researcher to generate a substantive theory explaining the experience of pregnant Thai women with preterm labor for participating in clinical decision-making.

Research design

The study was mainly based on Strauss and Corbin's grounded theory methodology (Strauss & Corbin, 1990 & 1998). A detail of the methods and procedures are presented.

Participants and settings

In the initial stage of data collection, twenty-eight were recruited, with two participants refusing to participate since one had no time for interviewing and the other was moving to other provinces. In the operational stage of data collection, twenty-six participants completed the interview. The participant recruitment was stopped since the data was saturated. Inclusion criteria for the recruitment were (1) confirmed diagnosis with preterm labor, (2) had hospitalization during preterm labor, (3) willingness and availability to participate in the study, and (4) ability to discuss and communicate well.

The settings used in the study were two public hospitals in Bangkok, Thailand. Both hospitals were providing health services for pregnant women with preterm labor. In general, the pregnant women with critical condition need hospitalization at the labor room, when their conditions were stable, the physician will refer them to antenatal ward. There are both medical and nursing schools affiliated with each hospital. In this study, the interviews took place privately in a room at outpatient department or in-patient wards or participants' home.

Instruments

In this study a personal information sheet, interview and observation guide were the data collect strategies. The research is the most important instrument in qualitative research. The personal information sheet was used to collect demographic characteristics of the participants and obstetrics history of participants. The interview

and observation guides were used to explore the experience in participatory clinical decision-making among Thai pregnant women with preterm labor.

The researcher as research instrument

In qualitative research, the amount and quality of the data and the depth of analysis are depended upon the ability of the researcher. In interviewing, the information elicited depends upon the ability of the interviewer to establish rapport and gain the trust of the participants or upon the researcher's interview techniques. In the participant's observation, the amount of information also depends upon observation skills and the amount of trust established. In addition, the depth of data analysis depends upon the researcher's sensitivity, perceptivity, informed value judgment, insight and knowledge (Morse & Field, 1996. For enhancing ability and skills such as interpersonal skills, interview and observational skills and analytical skills in conducting this study, the researcher prepared by studying and training in a qualitative research courses, and reading previous research studies, which were used grounded theory study as a research method.

Personal information sheet

The personal information sheet consisted of demographic characteristics and obstetrics history of the participants (Appendix C and Appendix D). demographic characteristics of the participants includes age, religion, marital status, educational level, occupation, income, type of family, and number of children; an obstetrics history includes, gravidity, parity, gestational age, abortion experience, preterm labor/ preterm birth experience, hospitalization experience, length of stay at hospital, readmission, chief complaint, and diagnosis.

Interview and observation guide

The interview guide contained three major sections, i.e., meaning of participatory clinical decision-making among Thai pregnant women with preterm labor, process of participation in clinical decision-making, and facilitating and inhibiting factors of participatory clinical decision-making (Appendix A and Appendix B). The interview guide was primarily used for guiding the initial interview. It was flexible and adjusts according to the information obtained from the interview. The observation guide contains two sections including the observation guide used to observe the participants' family, relationship, action/ interaction, event, incident, etc. during the home visit and the observation guide which was used to observe the participants action/ interaction, relationship, event, incident, etc during the participants' hospitalization. This observation guide was also flexible and adjusts according to the situation.

Data collection

Data collection procedures were initiated following the approval from the ethical committees, Faculty of Nursing, Prince of Songkla University, Thailand. The selected hospitals were contacted and asked for permission to conduct data collection. After obtaining permission, the researcher formally contacted and provided information on the objectives and procedures of the study to the hospital directors. The researcher also contacted the head nurse and the physicians who provide service to Thai pregnant women with preterm labor. After self-introduction, the researcher explained the study purposes, and procedures to each potential participant. The ethical

consideration was also addressed, particularly those of confidentiality, potential risks, and participants' right to withdraw or refuse to participate in the study. A consent form (Appendix E and Appendix F) was read and signed after each participant agreed to participate in the study. The convenient date, time, and place for interviewing were scheduled.

In this study, data collection included in-depth interview, observation during home visits and during participants' hospitalization, and reviewing patient records. Data collection and analysis were conducted simultaneously until theoretical saturation was achieved, i.e., 1) no new or relevant data emerged regarding a category, 2) the category was well developed in terms of its properties and dimensions demonstrating variation and 3) the relationships between categories were well established and validated (Strauss & Corbin, 1990; 1998).

In-depth interview

In-depth interviews were conducted after participants signed the informed consent form. The participants were interviewed by the researcher in a private room of the antenatal ward, or in their own homes, as preferred by participants. The semi-structured interview was used to explore the meaning of participatory clinical decision-making, process of participation in clinical decision-making, and facilitator and inhibitor of participatory clinical decision-making process. The first interview was to establish rapport between the researcher and participants. The participants were encouraged to answer all questions freely, and to ask questions as desired. The participants were assured during the interview that there is no "right" or "wrong" answers. The researcher initiated the interview with each participant with personal information and general questions by using interview guide, which was prepared by

the researcher (Appendix A). The second or additional interview was conducted to clarify the first or previous interview and explore further experiences of participatory clinical decision-making. The interview questions were developed for each participant from the previous interview. The interview questions moved from the general to particular. During the interview, the researcher attentively listened to what the participants said and encouraged the participants to clarify and elaborate the detail of their experience by using probing technique. At the end of each interview, the researcher allowed the participant to share any additional information that she wished to share. The interviews were conducted until reaching saturation of the data.

The data collection conducted during August 2006 to September 2007. The number and the length of interview for each participant varied according to the participant's condition and situation of each interview. Twenty-two participants were interviewed twice and four participants were interviewed three times. The length of each interview lasted approximately 30-70 minutes. Most of interviewing was took place at the participant's home. Only the first interview took at private room of antenatal ward. The second or additional interview was performed 1-2 weeks later depending on the participant's convenience. The participants who got acute exacerbation were interviewed after discharge from the hospital 1-2 weeks later or when their condition had stabilized after acute exacerbation. With the permission of the participants, all of the interviews were taped recorded and transcribed into written text by the researcher as soon as possible for the purpose of analysis.

Observation

Observation was used in conjunction with the interviews during the home visit and during the participants' hospitalization due to the participants sometimes

unable to report accurately about certain behaviors. Observations were used as additional means of obtaining information. Also, use of the method of observation could be considered as a strategy of validation to increase the credibility of the data collected by the interview and analyzed using qualitative method (Lincoln & Guba, 1985).

Reviewing patient records

The patient records were reviewed at least two times. The first review aimed to screen potential participants, while the second review aimed to obtain additional data from patient records to supplement the data as well as cross-check the data from interviews and observations. The review of patient records provides the important data such as participants' biography, history of illness, the results of laboratory studies, diagnosis, history of treatment or hospitalization, and present medical or treatment.

Human subject protection

Grounded theory approach includes interviewing and observation and it could create ethical issues such as confidentiality and potential risks such as during the interviews was increased tiredness or fatigue. Prior to undertaking the study, the proposal, interview guide, and subject consent form were approved by the ethical committee of the Faculty of Nursing, Prince of Songkla University and the two public hospitals. The ethical issues were concerned throughout the whole process of this study. Each participant was informed about the purpose and the nature of the study, potential risks, and the protection of confidentiality and her rights as a subject.

Written consent was obtained once they decided to participate in the study (Appendix E and Appendix F).

In order to insure the confidentiality of participants' data, tapes and transcription; notes; and computer files were secured in locked cabinets and destroyed after completion of the study. Participants' names were replaced with coding and pseudonyms. Only the researcher and advisory research committee were allowed to access the raw data. In publication materials, any identifiable characteristics changed to protect the identity of participants without altering the findings of the study.

The participants were willingness to participate in this study. A possible anticipated risk during the interviews such as increased tiredness or fatigue that affected on their pregnancy was monitored. The participants were informed to stop the interview if they felt tired or fatigues. In the study the participants were no risks during the interviews. Furthermore, the researcher informed the participants to feel free to talk their experiences regarding participatory clinical decision-making during their hospitalization due to preterm labor. Participants could also refuse to be interviewed if they did not want to discuss, or stop the interview at any time without any negative consequences on the services they received from hospitals. The address and phone number of the researcher was given to the participants so that they contacted the researcher and asked question. In this study, inform consent from participants was obtained before data collection. No participant reported any discomfort while being interviewed, nor did any participant withdraw during the interview. Many reported feeling relaxed during and after the interviews.

Data analysis

Data analysis and data collection proceeded simultaneously. The audio-tape recorded interviews were transcribed into verbatim text as soon as possible after collecting the data. Data analysis was conducted day by day and case by case. Textual data were analyzed using coding techniques, constant comparative analysis, memos and diagram writing throughout the analyzing process. The first three interviews were analyzed then theoretical sampling was used until the data were saturated and the model of participatory clinical decision-making was developed.

Data analysis was conducted with the help of the advisory dissertation committee members. Initial meeting was arranged for discussion on data analysis. The transcripts of the first three participants were used for initial open coding. Subsequent meetings involving the discussion on data analysis as emerging categories and their properties, relationship among involved discussion of the theory was conducted. These meetings with the advisory dissertation committee members were conducted throughout the period of data analysis.

Data was analyzed according to the strategies of grounded theory by Strauss and Corbin (1990 & 1998). The constant comparative method of analysis was used until core category reflecting the process of participatory clinical decision-making emerged. Coding process; theoretical sampling; memoing; and diagramming were used to develop the model of the process, is detailed as the followings.

Coding process

After the audio-tape recorded interviews were transcribed verbatim, three types of coding included open coding; axial coding; and selective coding, were

used (Strauss & Corbin, 1990; 1998). Each type of coding is detailed as the followings.

Open coding

The open coding was started as soon as the researcher received the data, which aimed to develop and conceptual labels from the raw data. This process was started with researcher breaking the data down by reading the data line by line and paragraph by paragraph, looking for incidents and facts. Similar incidents and phenomena were compared and contrasted with each other and similar phenomena were assigned the same name. In open coding, initial concepts were formed and developed into categories that reflected more abstract concepts. Their properties and dimensions were discovered in the data (Strauss & Corbin, 1990; 1998). Through open coding, major categories around the concept of participatory clinical decision-making emerged. The concepts that emerged from open coding provided a basis for axial coding.

Axial coding

The axial coding involved both inductive and deductive thinking. Axial coding was a set of procedures whereby data was put back together in new ways after open coding by making connections between categories. This is done by means of coding paradigm involving the following categories: causal conditions, phenomenon, context, intervening conditions, action/ interaction, and consequences. While examining the data, the researcher asked questions about the relationships between the categories then went back to the data to verify those relationships (Strauss & Corbin, 1990).

In this study, the researcher conducted and transcribed five participants' interviews. The researcher began to use axial coding for the data analysis. While comparing the categories and examining their relationships, the researcher recorded memos and drew diagram that represented the relationships. After categories and their relationships were redefined, categories were collapsed.

Selective coding

The selective coding was the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development. Steps in selecting coding include: (1) explicating the story line; (2) relating subsidiary categories around the core category; (3) relating categories at the dimensional level; (4) validating those relations against the data; and (5) filling in categories (Strauss & Corbin, 1990). In this study, learning to know what happened as a core category and used to guide additional data collection. More data was collected to elaborate the properties and relationships among categories and to validate those relationship and hypotheses. The characteristics of the participants and conditions under which different behaviors happened were examined and an effort was made to increase the diversity of the sample based on the characteristics and factors relevant to the core categories. Data collection and analysis continued until there was no new data about categories from the analysis.

Theoretical sampling

In this study, theoretical sampling was used to selectively collect additional data to develop the categories, hypotheses, elaborate the properties of the categories, and advance the model. Theoretical sampling was on the basis of concepts

with theoretical relevant to the evolving model. Three types of theoretical sampling, open sampling, relational and variation sampling, and discriminant sampling, were used to associate with open coding, axial coding, and selective coding. The aim was to sample events and incidents, not person, to gather data about action/ interactions strategies related to learning to know what happened, conditions giving rise to those actions, how conditions change or stay the same, and the consequence.

Memos and diagrams

Memos and diagrams were also used in conjunction with the coding process. Memos have been defined as written records of analysis related to the formulation of theory, while diagrams were visual representations of the categories and how they linked together. Examination of a diagram could point out where model needs further development. They were especially useful when the researcher was overwhelmed with memos and needed an overview of the analysis. Diagrams represented the relationships of categories in this study were shown in figure 1. Both memos and diagrams were useful to the researcher at any stage of the analytic process (Strauss & Corbin, 1990).

Four types of memos were used in this study. Methodological memos were used to record issues sampling and data collection, and to document key decisions. These memos gave direction for sampling, thing to look for, seek out, and ask about the next interviews and observations. Code notes were used to explain the meaning of conceptual labels and to show their relation to the raw data. Theoretical memos were used to develop ideas about the emerging concepts, categories, and their relationships. These memos contained the product of inductive or deductive thinking about relevant and potential relevant categories, their properties, dimensions,

relationships, variations, processes, and conditional matrix. Finally, personal memos were used to note the researcher's own feeling, reactions and reflections. These four types of memos were used continuous throughout the whole process of this study.

Trustworthiness

Trustworthiness was a basic requirement related to how the researcher could persuade readers that the findings of an inquiry were worthy and worth taking into account (Lincoln & Guba, 1985). The criterion of the trustworthiness of qualitative research included credibility, fittingness, auditability, and confirmability (Lincoln & Guba, 1985).

Credibility

Credibility was the criterion against which the truth value of the qualitative research was evaluated. Qualitative research was credible when it presented a faithful description of the human experience. Lincoln and Guba (1985) suggested that there were many techniques to increase credibility of qualitative research findings. In this study, researcher adopted the techniques to enhance credibility of the findings as follows:

Firstly, the appropriate participants, Thai pregnant women with preterm labor who had experience hospitalization were selected. In addition, they had willingness to be interviewed and to reveal the experiences. Trustful relationship between the researcher and participants were established before conducting in-depth interviews related to their illness. When the adequate trust and rapport were emerged, the participants shared their experiences openly. The researcher noted that in the

second or the subsequent interviews, the participants usually shared their experiences in more detail and their confidential personal matters were revealed to the researcher.

Secondly, triangulation was a mode of improving credibility of data. Data from different sources of information and different data collection modes were used to compare and verify with the forthcoming data continuously through the procedure of collecting and analyzing data. Interview, observation, and review patient records were used to collect the data. Triangulation of different investigators was also applied. Data analysis procedures of the first four cases were reviewed by an expert in grounded theory methodology and the overall analysis procedures were reviewed by advisor. Finally, the analytic categories, the interpretations, and the conclusions were criticized by the advisory committee and a nurse who experience in pregnant women with preterm labor. Their comments were utilized for consideration and improvement of the developed theory as well.

Thirdly, member check was another technique that was crucial for establishing credibility (Lincoln & Guba, 1985). The data, analytic categories, interpretations, and conclusions were tested with participants. Member checks were used continuously in the course of the investigation. A summary of each interview was described to the participants during the next interviews. Any errors involving prior data were corrected, and some data were clarified after discussing with the participants. Moreover, the interpretation and conclusion of the study were tested and discussed with four participants. They eagerly examined the interpretation and conclusion. They shared ideas and gave suggestions to the categories' named and their relations, as well as gave more explanation of their experiences. The researcher considered their suggestions and used them in developing the model.

Transferability

Transferability or fittingness appraised how well the working hypotheses or propositions fit into a context other than the original context of the study (Beck, 1993). Thus, transferability depends on the degree of similarity between sending and receiving context (Lincoln & Guba, 1985). The investigator was responsible for adequately describing the original context of the study so that the readers could possibly make a judgment of transferability. In this study, a thick description that included the explanation of the participants' background, the process of data collection, as well as the sufficient and relevant contextual information of each stage of the participants' participation in clinical decision-making process was provided.

Dependability

Dependability or auditability referred to the ability of another investigator to follow the audit trail which included all of the decisions made by the researcher at every stage of data analysis (Beck, 1993). In grounded theory approach, Strauss and Corbin (1990: 251) suggested that indication of reproducibility or auditability as follows: "given the same theoretical perspectives of the original researcher and following the same general rules for data gathering and analysis, plus a similar set of conditions, another investigator should be able to come up with the same theoretical explanation about the given phenomenon". Since the grounded theory process depended on the interaction between the data and the creative processes of the researcher, reflexive notes throughout data collection were kept as records. Cognitive trail of the researcher was immediately recorded in the form of memos.

Confirmability

Confirmability was the criterion of neutrality in qualitative research. It referred to the findings themselves, not to the subjective or objective stance of the researcher (Lincoln & Guba, 1985). Confirmability was ensured by the fact that the whole process of this study was coherent and the results of the study were logical. Words of the participants were quote appropriately and adequately to show that the findings were grounded in events rather than the researcher's personal construction.

Strauss and Corbin (1990, 1998) proposed two criteria to evaluate grounded theory research. The first judgment was made about the adequacy of the research process through which the theory was generated, elaborated, or tested. Another one was made about the empirical grounding of the research findings. Throughout the process of this study, the researcher asked ongoing question to evaluate the research process and the findings, and put effort to carefully and thoughtful follow the rule of grounded theory methodology in developing theory that met the two criteria for evaluation.

In conclusion, the study was conducted among 26 pregnant Thai women with preterm labor by using grounded theory approach in order to generate the model that explaining their participation in clinical decision-making. The setting for this study included in-patient and out-patient departments from two public hospitals in Bangkok, Thailand. Informed consent was obtained and the rights of all participants are protected. Data was collected by using in-depth interview, observation, and reviewing patient records. Most of participants were interviewed twice, two participants were interviewed once and four participants were interviewed three times. The length of each interview lasted approximately 50 minutes. Most of interviews were taken place

at the participants' home. Only the first interview was taken at private room of antenatal ward. The second or additional interviews were performed 1-2 weeks later depending on the participant's condition. The participants who got acute exacerbation were interviewed after discharge from the hospital 1-2 weeks or when their condition had stabilized. With the permission of the participants, the interview were recorded by using an audio-tape and transcribed verbatim. Data collection and analysis were conducted simultaneously until theoretical saturation was achieved. Constant comparative was used to analyze data according to the strategies of Strauss and Corbin (1998). The protection of confidentiality and the human rights of the participants were taken into account throughout the process of data collection. The trustworthiness of this study was established based on the criteria of credibility, transferability, dependability, and confirmability.

CHAPTER 4

RESULTS AND DISCUSSION

The purpose of this chapter is to present the details of the results of the data analysis and the discussion of findings. Firstly, the demographic characteristics and obstetric history of participants as well as the participatory clinical decision-making process are described. The evolving model of "Coming to Know What Happen: Women's Participation in Clinical Decision-making during Preterm Labor" encompasses two phases: a pre-hospitalized phase and a hospitalized phase. The pre-hospitalized phase consisted of two stages: recognizing something was wrong and its impact, and seeking help. The hospitalized phase included three stages: assessing clinical situation, taking part in clinical decision-making, and knowing what happened. The description of each major process and its components along with the relationships among them, generated from the grounded theory analysis, is provided. The common factors that emerged from data and that may influence the participation in clinical decision-making process are also presented. The second part is the discussion of the findings in each stage of evolving model.

Results

The presentation of findings from this study is organized as follows: 1) demographic characteristics of participants, 2) obstetric history of the participants, and 3) a discussion of each concept and how it fits into the theoretical paradigm is

described in detail. Exemplars from interviewed data in relation to each concept of the model are also presented.

Demographic characteristics of the participants

The demographic characteristics of participants are presented in table 1. The age of the women ranged from 16 to 37 years. The overall mean of the participants' age was 25.85 years (SD = 6.92). About forty percent were younger than 20 years. Most of the participants (76.92%) were Buddhist. Almost all of them (84.61%) were married and live with their spouse/ husband. More than half of them (57.69%) attended vocational school to master degree level. Almost half of them (46.15%) were employee. Most of them (65.39%) had an average income more than 10,000 baht/month. Two-thirds of participants (76.92%) lived in a nuclear family.

Obstetric history of the participants

The obstetric history of participants is shown in table 2. Over half of participants (65.39%) were primigravidas. Most of them (69.23%) were never experienced a delivery. Over half of them (69.23%) were in gestational age of 29 to 32 weeks. The average gestational age of the participants' was 32-33 weeks. Most of them did not have an abortion experience (84.61%). Participants who had experience of preterm labor and/or preterm birth were at 15.39%. Half of them (53.85%) had no experience of hospitalization. Participants' length of stay at hospitals ranged from 3 to10 days and average hospital stay was 4.5 days. Participant readmission was 11.54% and all of them were admitted at the same hospitals.

Table 1

Demographic characteristics of the participants (N = 26)

Demographic characteristics	Frequency	Percentage
Age (years)		
< 20	8	30.77
20-25	5	19.23
26-30	4	15.39
31-37	9	34.61
Religion		
Buddhist	20	76.92
Christianity	2	7.69
Islam	4	15.39
Marital status		
Single	1	3.85
Married	22	84.61
Widowed	1	3.85
Separated	2	7.69
Educational level		
Primary school	5	19.23
High school	6	23.08
Vocational school	7	26.92
Bachelor degree	5	19.23
Master degree	3	11.54

Table 1 *(continued)*

Demographic characteristics	Frequency	Percentage
Occupation		
Housewife	4	15.39
Employee	12	46.15
Business owner	4	15.39
Government officer	5	19.23
Nurse	1	3.84
Income (baht/month)		
< 5,000	2	7.69
5,000-10,000	7	26.92
10,000-15,000	9	34.62
> 15,000	8	30.77
Type of family		
Nuclear	20	76.92
Extended	6	23.08
Number of children		
None	18	69.24
One	5	19.23
Two	2	7.69
Three	1	3.84

Table 2

Obstetric history of participants (N = 26)

Characteristics	Frequency	Percentage
Gravidity		
First	17	65.38
Second	4	15.39
Third	3	11.54
Fourth	2	7.69
Parity		
None	18	69.23
First	5	19.23
Second	2	7.69
Third	1	3.85
Gestational age (weeks)		
29-32	18	69.23
33-36	8	30.77
Abortion experience		
Yes	4	15.39
No	22	84.61
Preterm labor/ Preterm birth experience		
Yes	4	15.39
No	22	84.61

Table 2 *(continued)*

Characteristics	Frequency	Percentage
Hospitalization experience		
Yes	12	46.15
No	14	53.85
Length of stay at hospital (days)		
3-4	16	61.54
5-6	7	26.92
7-8	2	7.69
9-10	1	3.85
Readmission		
Yes	3	11.54
No	23	88.46

Participatory clinical decision-making process

Using a grounded theory approach, data analysis reveals the participation in clinical decision-making process among Thai pregnant women with preterm labor. The findings showed that the basic social process, which emerged as the substantive process model, is "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor." The Thai pregnant women with preterm labor who participated in this study used a basic social process to carry on their participation in clinical decision-making. This part gives a detailed description of the basic social process and provides excerpts from the data to support the analysis.

The model of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor" that emerged from the data analysis was elaborated as below. It consisted of two phases: pre-hospitalized phase and hospitalized phase. The pre-hospitalized phase encompasses two stages and the hospitalized phase includes three stages. Each phase of the process is presented as below.

1. Pre-hospitalized phase

The pre-hospitalized phase, before participants decided to go to the hospital, included two stages: 1) recognizing that something was wrong and its impact, and 2) seeking help. In this phase, participants faced with the onset of preterm labor and interacted with family members or friends. The details of each stage were described as follows.

Stage 1: Recognizing that something was wrong and its impact

It is clear from the data that stage 1 started from participants recognizing that something was wrong and its consequences or impacts. The duration of stage 1 ranged

from 1 to 3 days depending on severity of the symptom. The action/ interaction strategies that emerged from the data in this stage encompasses: 1) perceiving abnormal symptoms; 2) being concerned about their baby's health status; and 3) worrying about the negative impact on their families, as presented in details below.

Perceiving abnormal symptoms

Pregnant women perceived abdominal pain and/ or bleeding per vagina and/or fetal movement change as abnormal symptoms in the light of their knowledge and personal experience. Eight of participants (30.77%) were multipara with the experience of pregnancy and giving birth. They compared their symptoms with the previous pregnancy as stated in the following examples:

> "…last Friday morning I felt a false labor pain like in my previous pregnancy. I knew that it was normal. Two days later I felt my baby movement decreasing. I worried the baby may be in jeopardy. Then, I felt like labor pain but I was not sure. I knew that it was an abnormal signs…" (ID.01-P5)

> "…In the early morning, I frequently urinated and felt a little abdominal pain. I could still, however, work at my office. Then, I found that the discharge from vagina looked like the mucus mixed to blood I thought that it was abnormal to have this type of discharge because the gestational age was just thirty weeks…" (ID.08-P8)

Four participants (15.39%) had experiences of preterm labor or preterm birth. The preterm labor or preterm birth that might become more serious made the participants realized that the severity and progression of symptoms not only threatened their lives and caused suffering to them but also forced them to acquire urgent assistance from health care providers to save their lives. The participants realized that their symptoms put their babies' life at risk. As a result, they sought help as it is clearly expressed in following quotation:

> "…My condition was quite different from the previous pregnancy. I got pain and I knew there was something wrong in my body but I don't understand what happened..." (ID.14-P3)

Being concerned about health status of their babies

All pregnant women with preterm labor revealed that they concerned about health status of their babies when they felt abdominal pain or a change in fetal movement. They also perceived that taking medicine during pregnancy put their babies at risk, so that they just monitored their pain or the change in their baby's movement. Most of them perceived that if they gave birth before 37 weeks of gestational age, the baby would be too small to survive. They perceived that when they got preterm labor, they would be a risk of preterm birth. This belief was based on their negative experience or on hearing from other people's negative experience. In this study, four participants (15.39%) had experienced preterm labor and/or preterm birth. Four participants (15.39%) had experienced abortion. This caused them to feel more concerned about their babies than pregnant women without history of these problems. Those women who experienced preterm labor or preterm birth, worried about the possible recurrence of preterm labor, as participants said:

> "…My first daughter was a premature baby. After birth, she had a lung problem and needed to use the respirator for a week. At that time, I was suffering when I looked at my daughter in incubator. I felt so sad and guilty. I prayed for my daughter everyday to get better soon. I hope that the event would not repeat itself..." (ID.07-P3)

> "…I had the experience of abortion. Now I have no children. This baby was my hope. I worried about my baby. When I got pain like uterine contractions, I would imagine the day I had lost my first baby. I felt very sad and cried the whole day..." (ID. 22-P15)

> "…This was the second time for admission with the same problem… uterine contractions and I got abdominal pain. At that moment I was not sure I could maintain the pregnancy. I worried about my baby…was too small to survive. I knew that I might be at risk for preterm birth..." (ID.11-P10)

> "…I had no experience of pregnancy. This was the first time I had abdominal pain. I got pain like the type of uterine contractions one gets during the menstrual period. It was quite painful and I could not tolerate it. At that moment, I thought that it was not safe for my baby…" (ID.14-P10)

> "…I was fearful…how about my baby? I was afraid that the baby would be abnormal. It made me anxious…" (ID19-P6)

> "…When I saw pictures of other babies' deformities from the television or anywhere, I feared that my baby would be similar..." (ID.02-P8)

Sixteen participants (61.54%) had a negative perception of pregnancy by hearing from relatives or friends who told them about bad experiences of pregnancy or by receiving the information from various media. They were afraid that preterm labor may occur to them. For example,

> "…I heard from my friend. She told me that if I gave birth before the expected date of delivery, the chance of having a mentally handicapped baby would increase. I tried to maintain my pregnancy as long as I could. …I worried about my baby. I hoped that my baby would be normal…" (ID.03-P12)

> "…My relatives had experiences of preterm labor. She told me that she was readmitted three times to receive drugs for inhibiting uterine contractions. However, finally she gave birth to premature baby and her baby was too small to survive. I worried about my baby. I prayed for my baby every night…"(ID.05-P7)

> "…Once I felt abdominal pain like menstrual cramp pain I worried about the baby. That night, I could not sleep. I had read from the maternal magazine that when the uterus contracts the oxygen in the baby's blood decreases. I feared that my baby might be dead..." (ID.06-P5)

Worrying about the negative impact on the family

Pregnancy is the joyful event for their family. By contrast, when women feel abdominal pain or perceive abnormal symptoms they worry that they cannot give birth to the new member for the family. This has a negative impact on their family. Four participants (15.39%) of preterm labor and/or preterm birth reported that they worried about the family members visiting them while they stay at the hospital. They had to take leave from work which resulted in the loss of family income. In addition, they needed to pay a lot for treatment. They felt that this was a burden for their families.

> "…At that time I felt abdominal pain. I thought about the last pregnancy with preterm birth, my mother and my husband made sacrifices to visit me everyday. Sometimes my husband would leave work to visit me. I felt that my mother and my husband were tired. My home was far away from here and they needed to wait for the bus for quite a long time…" (ID.15-P12)

> "…When I saw a preterm baby in an incubator, I felt sad and I suffered. She and her family was suffering and spent a lot of money to meet the cost of medical treatment. Her daughter is not healthy... I worried that these abnormal signs would have an impact on my family. My family is quite poor does not have money to pay for the treatment expense…I expected that event (have a preterm baby) would not occur in my family. I was praying everyday…" (ID.10-P9)

> "I imagined… if I was to have a preterm baby. I and my spouse would be in difficulty. I have not enough money to cure him…. I felt sad when I saw my niece; she was born when her mother was only on her thirty weeks of gestational period. She is mental handicapped. I would be suffering like in my brother's family if it happens to me (premature baby)..." (ID.05-P10)

> "…Now I have two children, a five and a two years old. If I had a preterm baby, it would be too hard for my family. My mother is sick with hypertension. My father has passed away last two years ago. My family is composed of four persons… my mother, my husband, and my two daughters. My husband work six days a weeks. I worry about the preterm birth impact on my family…" (ID.23-P7).

All participants described that after monitoring their pain and/or their baby's movement changes, they did not get better and could not perform daily activities. Thus, they needed to seek help. It meant that in this phase they tried to manage the symptom by themselves. Some participants revealed that they were carefully taking medicine for pain relief. If they could not get rid of these symptoms, they would seek help from other people such as spouse, mother, and friends.

Stage 2: Seeking help

Pregnant women who sought help by consulting with non-professional persons close to them were involved in this stage such as mother, spouse, aunt, sister, friend, or colleague. They sought help from these people and decided to go to the hospital The pregnant women received good support and care from their significant persons during this stage. It was clear that the spouses and mothers of the pregnant women were the most significant supporters and counselors. The duration of stage 2 was from 1 to 2 days. Seeking help stage including consulting spouse/ relatives/ friends, and deciding to go to hospital are presented as follows:

Consulting spouse/ relatives/ friends

Participants revealed that when they recognized something was wrong, they sought help by consulting their mothers, spouses, aunts, sisters, and friends. Most participants consulted women who already experienced preterm labor/preterm birth. However, the spouses and mothers of the pregnant women were the most significant supporters and counselors for them, as stated in the following examples:

> "…This is my first pregnancy. I am quite worried about my pregnancy and my baby. Last Monday… once I felt abdominal pain I called my spouse and told him about the symptom. He advised me go to hospital for the baby's safety..." (ID.25-P9)

> "...My mother lived together with me. When I had problems related to pregnancy, I often asked her and she gave me some good advice. She advised me go to the hospital after I told her about my pain. She said that I might be at risk of having a preterm delivery..." (ID.09-P13)

One participant told her spouse that he had to share the responsibility to care for the unborn baby, as she said:

> "…I told my spouse about the symptom…I got pain and the baby movement was not so good… because he was a father of my baby and it was his responsibility to know about our baby's condition or it was his duty to care for the unborn baby. That is the reason for telling my spouse. We have two children together…" (ID.23-P12)

In this stage, participants consulted their spouses; relatives; and friends, and then they turned to consult professional persons or health care providers in order to receive the appropriate treatment or care.

Deciding to go to hospital

All participants decided to go to hospital after discussing their abnormal symptoms with someone they trusted. Pregnant women decided to go to hospital in order to save the life of their babies and themselves, as stated below:

> "…I called my friend who already had preterm birth experience. I told her about my pain and the fetal movement decreasing. She told me that symptoms were not so good and suggested me go to hospital…I called my spouse to come home and take me to hospital. I decided to go to hospital to ensure the safety of my baby…" (ID.01.P8)

> "…I told my spouse about the pain. He thought my pain to be an abnormal symptom because my pregnancy was just only twenty-nine weeks of gestational age. He persuaded me to go to hospital. Then, I decided to go to hospital with him..." (ID. 03-P11)

Most participants perceived that their abnormal pain from uterine contractions could signify a risk of preterm labor and preterm birth. After consulting

their spouses, relatives, and friends, they decided to go the hospital. The findings of this study indicated that as soon as they decided to go to hospital, they selected the hospitals where they previously attended the antenatal clinic or the hospitals near their home for the reason that they were familiar with the health care providers, or that it was convenient for family members to visit. The spouses accompanied the participants to hospital, except some of them had to be accompanied by a female relatives because their spouse was not available.

2. Hospitalized phase

In the hospitalized phase, the participants were admitted to hospital. This included three stages: 1) assessing clinical situations, 2) taking part in clinical decision-making, and 3) knowing what happened. Each stage of process is described as below.

Stage 3 Assessing clinical situations

This stage started when participants were admitted to a hospital. Participants perceived that they encountered life-threatening situations which had an impact on their families. The participants needed to be informed and guided to interact with care-givers. It was therefore necessary to form a relationship with health care providers in order to facilitate the process of giving and receiving care. In addition, looking for appropriate time to interact with health care providers in order to explain about the problems and ask questions regarding the treatment or the needed care. The duration of stage 3 was from 1 to 2 hours. This duration depended on the personality of participants and the health care providers' attitude. The details of this stage were described as below:

Some participants disclosed th0at they can't cope with their problems. One participant expressed her feeling as below:

> "…At that time, I needed the way to relieve my pain anyway. The pain was very painful. I did not know how to express the feeling… Nothing to say only the words 'very painful' I suffered a terrible pain because of my uterine contractions …It hurt so much I complied with everything that the nurses' advised… This was the first pregnancy and I had no experience of preterm labor. I did not expected this would happen with me...At that time…it meant that during admission…I confused, focused only on my pain. I felt overwhelmed emotionally. I thought that crying was just one way for me to relieve my tension..." (ID.17-P8)

Some well-educated participants expressed their intention to consciously embrace the pain. Most of them were aware of the implications of preterm labor. After they were diagnosed with preterm labor, they attempted to take part in clinical decision-making. They assessed their clinical situation by acknowledging that their pain might be a life-threatening condition, by considering the impact of their pain on the family, gathering information about their problems in order to participate in clinical decision-making, making the relationship with health care providers, and seeking the timing to interact with health care providers. In this stage, some of participants revealed that the process of assessing the clinical situation depended on their cognitive skill, on their communication skills when dealing with nurses or physicians, on whether they would dare to tell the health care providers about their needs or their concerns. Some pregnant women were not brave enough to talk to the physicians, but they preferred to talk to the nurses or their mother because they believed that females could better understand women's problems. In addition, the severity of illness was taken into account in this stage. Some participants reported that

if they have severe pain, they must put themselves in the hands of health care providers.

Some participants claimed that they had the right of taking part in the treatment options. They could decline a requested treatment or any nursing procedures if they did not need that treatment or nursing procedures as advertised in the patient's right poster posted in front of the ward. One expectant mother expressed:

> "…I had signed the informed consent after I was admitted to the hospital. It meant that I could say "no", if I did not need that ultrasound because I had just been examined by the ultrasonography last Monday or three days ago. I thought it won't make any different and it would not be necessary to check with ultrasonography again. I had to pay a lot of money for the last hospitalization with the same problem (preterm labor)…"(ID. 14-P13)

In the stage of assessing the clinical situation consisted of perceiving their pain as life-threatening condition; perceiving impact of preterm labor on the family; seeking information about preterm labor; making relationship with health care providers; and looking for appropriate time to interact with health care providers. Each action/ interaction is presented below.

Perceiving their pain as life-threatening condition

Pregnant women with preterm labor perceived that their pain, referred to the pain resulting from uterine contractions, was the life-threatening condition especially in the cases whereby the pain was so severe, it would impair or jeopardize the pregnancy. Consequently, the preterm birth would occur. They worried about the baby's survival. One participant expressed the experience as stated below:

> "…In my opinion, during admission the patient needs to take part in decision-making by herself because it is a critical period or life-threatening situation. The patient must be fully aware of the treatment that she is about to receive so that she can decide for herself whether it is the right treatment for her or not." (ID.12-P8)

Some participants had experience of abortion or preterm birth worried about the life- threatening of their unborn baby. One pregnant woman with experience of preterm labor shared her experience as below:

> "…This situation was at a critical stage. It meant that if I was to make a wrong decision, I would feel guilty or be in conflict. However, I had to make a decision. At that time I believe I chose the best for my baby. My baby's survival was the first priority… I should know how the doctors or the nurses treated me but at that moment I was in pain and felt confused. I could not be sure when my pain would decrease..." (ID.20-P13)

Perceiving impact of preterm labor on the family

The pregnant women perceived that preterm labor would have an impact on the family. They considered the burden of having a preterm baby and how the inability to maintain the pregnancy would affect physically, psychologically and also economically. Some of the participants reported:

> "… On the first day of admission, I went to the labor room. I imagined "the day that I had the experience of abortion"…my spouse and my mother felt so sad because the baby was the first baby of my family. They were very disappointed after this bad event. In addition, I had fertility problems and difficulty in getting pregnant …I paid a lot of money for the treatment to get pregnant. If I had a preterm baby I would be pay much more money than if I had a term baby…" (ID.22-P14)

> "…The baby is a family's gift. Every body was waiting for the full term baby to be born. I knew that if I had delivered a preterm baby everyone in my family would suffer. I needed to maintain the pregnancy. At that time I hoped that I could continue my pregnancy. So I needed to know what the plan of treatment for me would be…" (ID.24-P16)

> "…I lived with my spouse. If I had a preterm baby my spouse and I would be in trouble. Nobody would help me to rear the baby…Moreover, after giving birth I had planned to go back to study..." (ID.17-P14)

> "…For the first admission, my mother and my husband made sacrifices to visit me everyday. Sometimes my husband would leave his work to visit me. My mother and my husband were tired. Moreover, my home was far from here and they had to wait for the bus for quite a long time…" (ID.06-P10)

Seeking information about preterm labor

Some of participants perceived that in this phase they struggled to engage in problem-solving, especially those participants who were not acquainted in dealing with emotional struggle and pain. They spent quite a long time assessing their clinical condition and finding a way to take part in their own care because they lacked the courage to join the clinical decision-making. They perceived that information was important in order to participate in care as one pregnant woman said:

> "…I did not know anything about preterm labor. I wanted to know about preterm labor. I just knew I was in pain. For me, it was impossible to take part in clinical decision-making. At that moment I was frightened by the unfamiliar health care personnel and the atmosphere when I looked at other pregnant women crying because of their pain while the nurses were very busy…So I put the responsibility on the hands of doctors and nurses. That way would be safe for my baby's life…" (ID.17-P15)

> "…I worked so hard, six days a week. I had three children …two daughters and one son. So, I did not have the time to access information regarding preterm labor. At that time, I wasn't ready to be involved in making decisions about the treatment…I had no idea. I thought that the doctors and the nurses should provide all the information for me. I needed the information about preterm labor…" (ID.15-P13)

Participants did not want to ask questions because they did not have sufficient knowledge to seek further information. Thus, they agreed to accept medical treatment despite no information exchange as indicated by the participants as follows:

> "…I don't ask. To think about it, I won't know much anyway. So, I don't ask. I just take the treatment..." (ID.21-P10)

> "…I thought of how I could possibly talk with physicians…I lacked information about preterm labor. After the nurse told me that I needed to be admitted for receiving the drug in order to relieve uterine contraction. I accepted her advice…" (ID.17-P8)

On the other hand, the pregnant women with a good level of education spent few minutes in this stage to assess clinical conditions. They accessed the information about preterm labor to share with health care providers. Also, some participants felt comfortable asking questions to the health care provider in order to know about the treatment regimens. This can be seen from the following quotation.

> "…Since I got pregnant I preferred to read magazines related to maternal and child health. I knew about preterm labor from various sources such as reading magazines, watching T.V. or listening to the radio. I knew how to talk to the doctor or the nurses and about the information I needed... I prepared my concerns to be discussed when they visited me. I was concerned about my baby because I already had an experience of abortion. I wanted to know my treatment regimens..." (ID.12-P16)

Making relationship with health care providers

Participants indicated that the relationship with health care providers was an important factor for being involved in participation of care. The health care providers are authorized persons and have a superior status than the patients because they have higher levels of education. Consequently, there is a distance in relations and communication between the patients and the health care providers. If the patients had

a good relationship with the health care providers, they could talk to them. The health care providers should share their power. Smiling; expressing respect and behaving in a polite manner; saying good words; and helping patients to follow the health care provider's suggestions, were the strategies to create a rapport between patients and health care providers. These would help the patients to take part in their clinical decision-making, as participants mentioned:

> "…I was quite familiar with the physician and the nurses in the labor room. So I could easily consult or ask questions or express my needs and concerns to them even though this is the first time of pregnancy…when I saw the doctor or the nurse smiling and saying good words I felt it were what I needed to build a good relationship..." (ID.16-P14)

> "…This was the second time to be admitted here. I was quite familiar with the nurses. They are very nice, friendly… pay attention and care for the patients. When I had any problem I could talk with the nurse. I thought I should follow her suggestions and express myself in a respectful manner. This helped me to build a good relationship with the nurse..." (ID.15-P9)

> "…The first day…I was frightened when I arrived at the labor room because that was the first time of my being hospitalized. . . I saw many pregnant women and one of them was crying …I thought that she was giving birth…she was painful with uterine contractions…I saw around the ward most of the pregnant women were receiving the intravenous fluid. I quite feared… I often tried to talk to the nurses and ask about my baby's condition. They tried to talk to me even though they were busy. The nurses had a friendly manner. I should follow their suggestions and express myself in a polite manner. My first impression was good and that made it easy to talk with them..." (ID.19-P9)

> "…I was shy to talk to the doctor. I was afraid that he would blame me. So, I just waited to hear from him. But I thought that if I followed his suggestion, I would make a good relationship with him..." (ID.17-P8)

In addition, some participants revealed that the personality of health care providers was the factors that influenced their relationships. If they were able to

make a good relationship with the health care providers, this facilitated them to take part in making a clinical decision as some participants expressed:

> "…Her smiling face with friendly manner helped me to talk to her (the nurse). I dared to talk to her anything. She understood my problem and supported me. I trusted her. She never blamed me even sometimes I asked the same question in order to confirm. She treated me as a person…" (ID.07-P6)

> "…I wanted to see the nurse with the sense of humor. I thought that this atmosphere helped me to release the tension and I was comfortable to talk to her. I disliked seeing the nurse who would talk to the patients with an authoritative attitude …such as "you must do that"…she looked to the patient as if they were children…patient must follow her…" (ID.11-P8)

Looking for appropriate time to interact with health care providers

Some participants perceived that the difficulties to achieve participation in clinical decision-making resulted from inadequate time for patients to interact with health care providers, as participants stated below:

> "…I saw the doctor and the nurses were very busy. The doctor told me about the treatment regimens. Then, the nurse took the drug for relieving uterine contractions to me and took the blood test before giving the drug via intravenous fluid. The nurse explained about the drug for me and I would have liked to ask about the blood test. She looked busy. Then, I postponed my question…" (ID.26-P12)

> "…I had the courage to talk to the nurse. She has a friendly manner, but she looked busy. I was afraid that she would not answer my question if I had asked her..." (ID.14-P10)

> "…The doctor and the nurses visited me every day in a hurried manner. I would have liked to ask them some questions but I changed my mind. Sometimes I thought to open my mouth and talk but they walked away. I understood they were very busy with a lot of patients waiting for them..." (ID.21-P12)

> "…The time was important for me. For example, if the nurses could not provide the time for patients, they would not know the patient's real problems. They treated only the physical symptom, but they could not treat the patients as a whole person…" (ID.23-P13)

> "…The nurses took the blood pressure, fetal heart sound, uterine contraction…and so forth. It was the routine of their work. Some nurses didn't have the time to listen to the patients' problems. They were very busy…" (ID.04-P8)

Stage 4: Taking part in clinical decision-making

This stage was triggered when the pregnant women took part in clinical decision-making. From the findings of the study, taking part in clinical decision-making was classified as two types: active participation and compromised participation. For active participation, participants took part in clinical decision-making by sharing information; asking question; reporting difficulties; perceiving that they know their problems best; preferring specific communication; seeking information regarding the treatment options; bargaining for their needs; planning for discharge; and making final decision with health care providers. On the other hand, in compromised participation, the pregnant women used strategies to participate as included: complying with health care providers' suggestion; putting the responsibility in the hands of health care providers; perceiving that health care providers know best; preferring one-way communication; waiting for information from health care providers; feeling reluctant to express their needs; accepting one's own illness as a product of one's own "fate"; and making a final decision in the hands of health care providers. The duration of stage 4 was from 1 to 3 days. Each strategy of this stage is presented.

Sharing information

It can be seen from the data analysis that all of the pregnant women with preterm labor in this study required information to make a competent choice. Participants obtained information regarding preterm labor and about the treatment in

different ways such as talking to health care providers, listening to pregnant women experiencing preterm labor or radio, reading books about preterm labor, and watching the television regarding pregnancy. The participants expressed as stated below:

> "…As far as I'm concerned the hospital is a place where I don't really ask questions…Information was thought to be too technical, difficult to understand. However, I wanted to share my information with the nurse and the doctor. This way could help me to participate in making a decision..." (ID.21-P15)

> **"**…Yesterday I could not sleep. I worried about my baby. I told the doctor and he told me about his plan that if he could not inhibit uterine contractions, he would terminate pregnancy because I had been readmitted two times already. This time he thought that the baby was near term…I told him that I wanted to terminate pregnancy…" (ID.11-P10)

> "….I told about my problem meanwhile the doctor or the nurse explained to me about the treatment regimen or the plan of caring…I would have liked to talk to him about the information that I heard from the radio and the television regarding preterm birth..."(ID.02-P11)

Participants frequently remarked they had received insufficient or inadequate information. Though further investigation often revealed the information they really wanted was to be told clearly what to do and what to expect.

> "…I would have liked the doctor and the nurse to tell me what I should do after I told them about my pain or my concerns. I wanted to know the planning of treatment. If I talked with the nurse or the doctor I should be able to know what would happen to me…" (ID.25-P9)

> "…After telling my symptoms, the doctor told me I had preterm labor. At that moment, I was quite frightened. He explained the plan of treatment. He suggested me admitting to receive drug for inhibiting uterine contractions was necessary. I agreed with him… The nurse told me about pregnant women on the next bed with the same symptom as me, now she got better after receiving drug and was transferring to the antenatal ward to continue observation…" (ID.22-P15)

Asking questions

From the data, it showed that during hospitalization the strategy was that pregnant women sought the information by asking questions from the health care providers as some participants revealed:

> "…everything that I didn't understand I raised the questions to ask the nurses or the doctors when they visited me. They explained me clearly and I understood…" (ID.11-P10)

> "…The best way that helped me to understand my symptom and my treatment was asking the doctor or the nurse. I could know how I could do. For example, the nurse told me I needed to bed rest. Yesterday, I got better. I asked her could I walk to toilet… " (ID.20-P.13)

> "…I always questioned if a test was necessary and why it was being done. The first day of admission I had a lot of treatment such as blood test, urine test, ultrasound, fetal monitoring, intravenous drug, and injection the drug for baby's lung maturity. I asked everything that the nurses provided for me. I believed that the treatment invasive not only my life but also my baby's life..." (ID.16-P8)

Reporting difficulties

Most pregnant women with preterm labor reported that choosing the best for their baby might not be the best for themselves as mothers. For example, the participants suffered from the side effects of tocolytic agent or the drug for inhibiting uterine contractions as one participant expressed:

> "…After receiving drug for relieving uterine contractions I felt palpitation. That night I could not sleep I asked the nurse about the effect of drug on the baby. I was anxious the increasing of my heart rate and my baby could tolerate or not. If my pain relieved, my baby could survive or not. I told the nurse about my problem and she decreased the rate of drug. Then, I got better..." (ID.04-P9)

Some participants needed to rest in bed for a long time and became constipated which in turn would lead to uterine contractions. Thus, they should report to the nurse as one participant claimed:

> "…I slept on the bed for three days. I felt constipation. The nurse provided the bed pan for me. I told her I prefer to go to the toilet because it was so hard for me to sit on the bed pan. Then, she helped me to the toilet. She told me that constipation is the leading to uterine contractions…" (ID.21-P7)

> **"**…It was boring to bed rest. The abdominal pain had diminished. I wanted to go back home. I waited for the doctor to visit, and asked the nurse when I could go back home. She said that I should ask the doctor and she thought that the doctor might discharge me today… (ID.17-P12)

Some pregnant women with preterm labor also revealed that their concerns were not only about their health problem but also about the financial and social problem. Some participants shared their experience:

> "…When the doctor told me the treatment, I would consider the cost and benefit because I paid medical expenses by myself. I stayed at hospital I could not earn money. I was afraid that I had not enough money to pay for medical expenses. I told the nurse about my financial problem…" (ID.04-P8)

> "…I just stopped working from my office since the last three months. So I paid the medical expenses by myself… After giving birth, I planned to continue studying… My spouse did not have enough money to pay the medical expenses. I consulted my problem with the nurse…" (ID.01-P7)

Perceiving they know their problems best

The participants described that their problems were not only physical but also psychosocial and economic problems and that they were reluctant to tell the health care providers. So they needed to consider the whole problem by themselves after health care providers' suggestions. Some participants said:

> "…Sometimes I also thought having this problem was quite a waste of time. I had to come to the hospital again and again. My husband was not rich and I needed to spend money for the transport too. I believed that sometimes the doctor and the nurse did not concern my psychological and social impact. They just cured me the physical problem. I knew the best of my problem… " (ID.11-P9)

> "…I just separated with my husband for three months. I could not tolerate to live with him. I moved back to live with my mother. I had one daughter with four-year old. My daughter lived together with me. When I was hospitalized I concerned my daughter. She cried everyday to sleep with me. After I got better, I would like to go back home as soon as possible. I could not sleep at night I missed my daughter and worried about her... The doctor told me. I must take oral medicine for inhibiting my uterine contractions. I told him I want to take oral medicine at home because of my family problem that sometimes the doctor and the nurses did not know..." (ID.07-P8)

Preferring specific communication

According to sharing information with health care providers, the communication skill was important for pregnant women with preterm labor to communicate with health care providers. They preferred the specific communication including two-way communication and partnership communication. Most participants revealed that two-way communication or the use of open question was better than the use of closed question. Health care providers were able to listen to their problems and suggested the ways to manage their problems. This strategy prevented misunderstandings. One expectant mother said:

> "…When the doctor visited me, they often asked me "how are you?" I told him about my needs. He explained the plan to discharge me and give me oral medicine for home medication. I asked him to ensure that I could go back home tomorrow…" (ID. 22-P14)

According to the partnership communication, some participants disclosed that when the health care providers talked about the treatment regimen, they

preferred the term “We”, “Our” or “Us” rather than the term “You”, “Your”, “I” or “Me”. It meant that they were working together to maintain pregnancy. Some pregnant women in this study said that:

> “…I didn’t like the doctor or the nurse to give order to me such as you must on bed rest, you must follow the doctor’s suggestions. It felt like my activity was under control of the doctor or the nurse. I didn’t have the freedom. I preferred the doctors or the nurses to talk to the patient with the sense of “we should do that…or how we do that…it meant that we were take responsibility together.” (ID.23-P14)

> “…When the nurses used the term of “you” or “your”, it looked like having the gap with the patient. If changed to the term “we” or “our”, I thought that it would be narrowed down the gap between the nurses and the patients. I also believed that some nurses didn’t pay attention of this term...” (ID.12-P10)

Seeking information regarding the treatment options

Seeking information regarding the treatment options was one of the strategies that participants used in order to take part in clinical decision-making. They believed that information was a crucial factor for participating in clinical decision-making. They sought information regarding the risk and benefit of each option. Decision-making required information with which to make a competent choice. Most participants focused on the side effects of tocolytic drug or drug for inhibiting uterine contractions as one participant stated:

> “…Well…at the beginning, I have already known that I need to maintain pregnancy for the safety of my baby by taking the drug for inhibiting uterine contraction. As I already said, the doctor told me that the drug was important even the first choice of drug has side effects. The nurse also told me about side effects of the drug. So, it’s like I have already known what is going on. I felt confident in taking the drug…” (ID.11-P9)

> “…I heard from my friend about the side effects of drug. I was afraid that I could not tolerate the side effects. I asked the nurse if I felt not so good what I could do...” (Pregnant woman ID.05-P5)

> "…I obtained information about the side effects of medicine from the leaflet that the nurse gave me after receiving the drug. It had some points in the leaflet that I didn't understand. I asked the nurse. She explained to me and I understood…" (ID.06-P8)

Bargaining for their needs

Participants bargained the treatment options with the health care provider when they felt the other option was better. They also negotiated about the length of time stay at hospital was an issue that they often talked with health care providers. Some pregnant women mentioned:

> "…I was afraid of the injection needle. It was extremely fearful because I had never received intravenous fluid before…I did not want any more pain. It was the terrible pain that I had. I told the doctor to take oral medication instead of intravenous drug. He said 'we would try if it could not inhibit we needed to change back to intravenous drug later."(ID.12-P8)

> "…The doctors suggested leaving from working for a couple of weeks. I thought that it spent too long. I told him I got better. Could I leave for only one week? I was afraid of the impact on my business…" (ID.04-P5)

> "…I knew the treatment regimen. I would like to try to talk to the doctor. Could I take oral medicine instead of taking the subcutaneous drug after receiving the intravenous drug?" (ID.12-P9)

Planning for early discharge

Participants disclosed that as soon as they got better they planned to be discharged because of having to take care of children, doing housework or solve financial problems. Moreover, some participants found resting in bed quite tedious and they reported about the boredom of waiting to be discharged from hospital as some expectant mothers said:

> "…two days later, I felt better and the doctor plan to discharge me tomorrow. I asked about the drug from the nurse. She explained me and told me about how to prevent uterine contractions again that leading to preterm birth and gave me the leaflet regarding prevention of preterm birth. I assumed that I carried heavy things like taking my daughter and lifting heavy thing resulted in my pain. So I would avoid carrying heavy things and bed rest more…" (ID.15-P16)

> "…I was afraid of readmission because I have abdominal pain again after the doctor discharged me for two days..." (ID.06-P14)

> "…After transferring to the antenatal ward I have uterine contraction again and needed to transfer back to labor room to receive drug for inhibiting uterine contractions. I was afraid of that…" (ID.13-P10)

Making final decision with health care providers

Interestingly, the interview data indicated that participants profoundly understood their problems. Thus, they should make a final decision by themselves, as some pregnant women described:

> "…I told doctor about my symptoms and he told me about the therapeutic regimen. Some problems I had not talked to him such as my financial problem or the limitation of my family. My spouse had passed away and I earn money for my family alone. So he could not know really problem. When he suggested me I needed to consider my problem again. Finally, I made the decision by myself. Then, I told my decision to doctor..." (ID.03-P12)

> "…I was afraid that after birth the baby might have respiratory disease because of lung immaturity. It needed long term treatment. I decided to maintain pregnancy as the doctor suggested… (ID.12-P4)

As indicated above, pregnant women need to have nursing and medical information before they can feel confident in making decisions about their care. The choice they make is based on the concerns for the baby well-being and on considering the impact on their families. There were nurses who were willing to share information with pregnant women and work with them as partners. These nurses exhibited

behaviors such as spending time with pregnant women, talking with them about their individual needs and concerns, volunteering information without being asked, actively listening to pregnant women and accepting their decisions.

However, some participants in this study had deferred to health care professional opinion, allowing their choices to be decided for them. As a contrast in some cases, some participants compromised with the health care provider. They used other strategies by complying with health care provider's suggestion, putting the responsibility in the hands of health care providers, perceived health care providers know the best, preferring one-way communication, waiting information from health care providers, being embarrassed to express their needs, accepting of illness as product of one's own "fate", and accepting health care providers decision. One participant expressed:

> "…I always felt inferior when I was with the doctor or the nurses I didn't dare to tell them about my needs.. I should follow the doctor's or the nurses' advice. I believed that if I against them, I was afraid that I would not receive a good care from them…" (ID.13-P10)

Some participants in this study revealed that they preferred to comply with health care providers. They claimed that they would like health care providers to feel good with them. If they went against their suggestions, it would have been difficult for health care providers to work. It meant that the health care providers would spend time to persuade them with suggestions as some pregnant women with preterm labor said:

> "…I was afraid to say what I concerned or I needed. I was carefully said anything that making the doctor or the nurse felt not so good (*greng-jai mhor*)… They were knowledgeable persons and I trusted their capability to treat and care for me. I hoped that they provided the best care for me. I should comply with the doctor and the nurse's suggestions. This was the best ways for me..." (ID.21-P10)

> "…My educational level was only primary school, so I could not involve in making a decision that is the responsibility of the doctors and the nurses. They were the expertise. I should follow their suggestions. I lacked of information to participate in making a decision with them. Everything depended on the doctors and the nurses. I believed that they chose the best for me…I *greng-jai* that is fear of offending them (the doctor or the nurses) or causing them (the doctor or the nurses) inconvenience or looked up the doctor or the nurses with great respect..."(ID.05-P12)

Stage 5: Knowing what happened

This stage was the consequence or outcome of model of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor". It meant that pregnant women learn to know what happened when facing onset of preterm labor and participated in clinical decision-making. This stage included understanding what happened and partial understanding of what happened or wondering what happened.

1. Understanding what happened

Eighteen participants (69.23%) understood what happened to them while they were facing preterm labor and being involved in clinical decision-making. Satisfaction of involvement in clinical decision-making; confidence of maintaining pregnancy until term pregnancy; and hope of healthy baby, were their perceptions of understanding what happened to them. The duration of stage 5 was from 3 to 4 days depended upon the complicated problem of pregnant women.

The understanding of the preterm labor led the participants to behave properly to restore their health. This was clearly stated in the following quotation:

> "…During I hospitalized, I had received information about preterm labor from the doctor and the nurses every time when they visited me. They explained quite clearly the treatment regimens or the nursing procedure. The nurse advised how to prevention my preterm labor. I was able to see a picture that I should do for my baby. This was the good for me to have a chance to learn my problems…" (ID.19-P14)

According to the understanding of what happened to them, the strategies that participants expressed as understanding what happened were: perceiving satisfaction of involvement in clinical decision-making, perceiving confidence of maintaining pregnancy, and perceiving hope of a healthy baby. Each strategy is described as follows:

Perceiving satisfaction with involvement in clinical decision-making

Participants in both active participation in clinical decision-making and compromised participation.were satisfied with their involvement in decision-making if there was congruence with the degree of involvement that. Some participants revealed that if they achieved the goal to understand what happened, they would be satisfied with the involvement in clinical decision-making from health care providers as some pregnant women with preterm labor said:

> "…I waited for the nurse who worked in the last night shift. I would like to ask her about my problems that I thought that she was only one who understood me. She listened to my voice. She was very good nurse with friendly and explain about preterm labor until I understood what happened to me… I satisfied with my opportunity to take part in making a decision about the treatment…" (ID.04-P6)

> "…I had stayed at hospital for four days. The doctor and the nurses were very nice with friendly manner. They listened to my problems and explained for me quite clearly even though they were busy. I appreciated them..." (ID.25-P12)

> "…I was able to know that how the doctor and the nurse manage the risk of preterm birth. I felt satisfied with involvement in making a decision regarding my health problem. They (the doctor and the nurse) explained every step of treatment regimen. I understood what happened and knew that how to prevent the preterm labor..." (ID.22-P9)

> "…I was so good and with the knowledge that I have been received about my condition that has brought me into hospital..." (ID.11-P10)

Perceiving confidence of maintaining pregnancy

After receiving the treatment that they agreed upon after taking part in making the decision, some participants got better. Consequently, they had a great deal of self-confidence of maintaining their pregnancy until term pregnancy as one participant revealed:

> "…I assumed that my pain resulting from lifting heavy thing. So I would avoid lifting heavy thing that resulting in uterine contractions…The nurse advised the prevention of preterm labor and I asked my question and she explained me clearly. I believed in my own ability for maintaining my pregnancy…I satisfied with my involvement in making a decision about the treatment..." (ID.07-P13)

Perceiving hope of healthy baby

All pregnant women with preterm labor expected that their babies would be a full-term healthy baby. They would feel overwhelmed to have a new family member especially in primigravida participants. Some participants expressed the experience as follows:

> "…I anticipated that I would be able to continue my pregnancy. Preterm labor would not be recurrence. I believed that I could overcome my problems…I thought that the treatment that I involved in making a decision was the best treatment. Certainly, I extremely expected that I must have a healthy full-term baby..." (ID.20-P14)

> "…I was praying every night for my healthy baby. I was looking forward to seeing my baby. I believed that my baby would be full term baby because I had the chance to share my problems with the doctor throughout my hospitalization. My spouse touched my unborn baby and said: 'be healthy baby… father was praying for you and waiting for seeing healthy baby …I attempted to do the best for my baby in order to prevent preterm labor..." (ID.23-P12)

However, some participants mentioned that they did not fulfill to understand what happened to them when facing with preterm labor during hospitalization. In this case they partially understood of what happened or wondering about what happened.

2. Partial understanding or wondering of what happened

Eight participants (30.77%) pointed out that they could not take part in clinical decision-making. They believed that the clinical decision-making was a responsibility in the hands of the health care providers. Uncertainty of preterm labor; anxiety about preterm birth; and conflict with health care providers, were the participants' perceptions of wondering what happened or did not achieve the active participation in clinical decision-making on account of the fact that they were not ready to be involved in their own caring because of their critical conditions, lack of knowledge, their shyness, and their cultural influence.

Perceiving uncertainty of preterm labor

Two participants (7.69%) did not understand what happened to them while they were admitted to hospital. They perceived uncertainty of preterm labor as one participant expressed:

> *"*…While I stayed at hospitals, I didn't know when I could go home, when I got better… I was readmitted to antenatal ward three times. I was not sure when my pain (preterm labor) diminished. I was boring to bed rest and did not know what happened. Everything depended on the doctor..." (ID.13-P10)

Perceiving anxiety about preterm birth

Two participants (7.69%) expressed that they felt anxiety about preterm birth, as they mentioned:

> "…Even though I received the treatment, I felt not got better. The doctor told me did not worry about my pain. But I could not sleep well, I was afraid that I would have preterm baby…" (ID.15-P11)

> "…This was the second time that I was readmitted with the abdominal pain or the same problem as the first time…I stayed for two days then I was transferred to antenatal ward again. I was boring to bed rest. At that time, I thought that if I could not get better. I would attempt to change the doctor or move to other hospital with the reason of why I could not get better. I didn't understand what happened to me. I asked the nurses why I could not get better. I was afraid that I would give birth to preterm baby. She could not explain me clearly and tell me to ask the doctor when he visited..." (ID.06-P9)

Perceiving conflict with health care providers

Four participants (15.38%) mentioned that they had the conflict with health care providers. They could not know the reason for the treatment as participants said:

> "…I did not agree with the physician for admission me a long time just taking oral medicine to relieve the pain and bed rest. I thought that I could go back home to take oral medicine and bed rest at home was better…I was boring to bed rest. I did not know what reason the physician did not discharge me. The nurse told me my fetal heart sound was OK…When I told the physician…I want to go home. He just said …wait for…wait for…." (ID.21-P.12)

> "…I doubted that why the doctor didn't terminate my pregnancy because it near term as the last pregnancy I gave birth as about this gestational age at provincial hospital. My first baby was healthy. I didn't dare to ask the doctor. I afraid that he would be not so good sense as not trust him. It was impossible to say that with him, it was not appropriate manner. I assumed that it was a hospital policy treatment of every pregnant woman with pain before the expected date of confinement..." (ID.20.-P12)

> "…I did not know why I stay at antenatal ward for a long time with bed rest. I could not go anywhere. The nurse said that if I would like go home I should bed rest. I didn't know the reason why I must bed rest more than other patients with the preterm labor as me. The first day in my patient's room had four patients. Next day three of them were discharged from hospitals they stayed at that ward only one night… I doubted why I stayed for three nights even I got well…" (ID.08-P8)

According to participants gained information from health care providers, some participants described that they struggle to get information and to be involved in decision-making. One participant expressed that:

> "…I asked about my baby's condition. The nurse said, it was OK…I wanted to know the numbers. She said "you didn't need to know that…I felt upset…why I could not know…what the reason..." (ID.23-P9)

Sixteen participants (61.54%) accepted a compromise to participate in decision-making, but after reflection expressed a desire for more active participation. They revealed that they would participate in decision-making next time as one expectant mother said:

> "…I thought that participation in decision-making was so good even this time I could not have the chance to take part in decision-making. I took my responsibility on the hand of the doctors and the nurses. At this time I got the experience of preterm labor and hospitalized experience. I believed that it's not hard for me to involve in decision-making. I had a chance to learn how to involve in decision-making. Nurses always asked my opinion and encouraged me to make a decision. I embarrassed to say anything. Now, I thought that I should take responsibility to make decision by myself. This was my life and responsibility of mother to protect the unborn baby's life. I should involve in decision-making next time..." (ID.25-P14)

Five participants (19.23%) revealed that they are facing possible health problems for their babies. These participants sometimes chose a passive role in decision-making about their health care. They accepted decisions directly or indirectly encouraged by health professionals when making decisions at time of anxiety and under pressure. It was possible that the pregnant women in this study who described "want to participate in making a decision next time," that is, to be more actively involved in making decisions, recognized that their passive involvement was related to their uncertainty during a time of crisis and their vulnerability to the influence of health professions. The participants revealed that the participatory clinical decision-making was a dynamics process and it changed overtime. Some participant achieved to participate in clinical decision-making and understand what happened. However, some participants were not fulfilled in their understanding of what happened. Partially understanding what happened or wondering what happened was the participants' perception. Two participants (7.69%) revealed that they would seek help by transferring to other hospitals. The process of participation in clinical decision-making would be going on again. (Figure 1)

In conclusion, the process of participation in clinical decision-making of Thai pregnant women facing with preterm labor from stage 1 to 3, the needs and concerns of the pregnant women focused on the survival of the babies. In stage 4 and stage 5 their attentions shifted to the prevention of preterm labor, family and economic impacts. Obviously, concern for the baby well-being had occurred throughout the process. The model that emerged from the study includes two phases and five stages. However, common factors that emerged from the data may influence the participatory clinical decision-making process in each stage are presented as below.

Factors influencing the participation in clinical decision-making process

According to participatory clinical decision-making process, the common factors that may influence the process in each stage are presented as below:

Stage 1: Recognizing that something was wrong and its impact

Recognizing that something was wrong is the result of perceived abnormal symptoms, concerning their babies, and worrying about the negative impact on their families. The onset of preterm labor brings about physiologic, psychosocial and functional consequences for the pregnant women. The common factors that emerged from the data as influential on the first stage were information about preterm labor, and past experiences of pregnancy/ delivery/ abortion/ preterm labor, as participants revealed:

> A pregnant woman with G_1P_0, 32 weeks of gestational age, said:
> "*I heard from the nurse* at the antenatal clinic about labor pain would occur after 37 weeks of gestational age but I felt pain meanwhile my pregnancy only 32 weeks of gestational age. I thought that it was not good." (ID.06-P2)

A pregnant woman with G_2P_1, 34 weeks of gestational age, said:
"*Previous pregnancy*, I gave birth to baby with 39 weeks of gestational age but last 3 days I felt abdominal pain with my baby movement decreased. I believed that it was abnormal symptoms." (ID.04-P6)

As a contrast case regarding the information about preterm labor, a participant with G_1P_0; 35 weeks of gestational age; mentioned:
"I got abdominal pain with having discharge from vagina looked like mucous. I worried about my baby. I thought that it was abnormal *I didn't know what happened*. I couldn't sleep all night." (ID.02-P3)

Stage 2: Seeking help

The second stage of process was seeking help which took place when pregnant women looked for other people to confirm the symptoms being experienced as a sign that something was wrong. The common factors that emerged from the data as influential on the stage were family relationships, information related preterm labor, past experiences of preterm labor, and educational background. Each factor is described as below:

A pregnant woman, 34, primigravida, 30 weeks of gestational age, with extended family, said:
"*My mother* lived together with me. When I had any problems of pregnancy, I *often asked her and she gave me good advices*. She suggested me to go to the hospital after I told her about my pain." (ID.09-P13)

A participant, 20, primigravidarum, 35 weeks of gestational age, with nuclear family revealed that:
"Since I got pregnancy, *my spouse paid more attention to me*. We are waiting for a full-term healthy baby that will be born. When I told him about my pain, he worried about the baby and suggested me go to the hospital." (ID.05-P8)

A pregnant woman, 37, G_2P_1, 35 weeks of gestational age, said:
"…this was the *second time for admission with the same problem (preterm labor)*…I knew that I might be risk for preterm birth. I should go to hospital" (ID.11-P10)

A participant, 33, primigravidarum, 29 weeks of gestational age, with the *Master degree*, reported that:
"I *knew that* my pain was abnormal and *needed to go to hospital*. …I am a *nurse*, so I knew that how to manage my pain" (ID. 16-P10)

> A expectant mother, 30, G_2P_0, 30 weeks of gestational age, with the *Master degree* (MBA) educational background, mentioned that:
> "I read from the maternal heath magazine about preterm labor. *I knew that* my uterine contractions were not normal… *I needed to go to hospital*…" (ID.22-P3)

Stage 3: Assessing clinical situations

The stage took place after participants were admitted to the hospital. They interacted with health care providers in order to receive the treatment. The common factors that emerged from the data may influence on the stage consisted of information about preterm labor, severity of symptom, and patient-health care provider relationships.

The information about preterm labor associated with educational background. Well-educated participants easily accessed information about preterm labor by reading or listening or watching television or searching from websites. Adequate information helped participants to take part in clinical decision-making as participants revealed:

> A pregnant woman, 31 weeks of gestational age, with the educational background was Bachelor degree said:
> "*I got information about preterm labor from the nurse and read from* the magazine, so I could discuss with the doctor regarding my treatment. I had the chance to share my opinion and I chose the treatment that the doctor suggestion confidently" (ID.24-P10)

On the other hand, the example of perception of participants with the high school educational background stated:

> A pregnant woman, 35 weeks of gestational age, with the *high school* educational background revealed:
> "*I didn't know about the details* of my treatment. My treatment was depended on the doctor made a decision. So I *didn't have any question to ask* the doctor or the nurses." (ID.02-P5)

In addition, the severity of symptom and patient-health care provider relationships were the factors that could be of influence on the stage, the expectant mother expressed that:

> "At that time, It was so *hard for me to make relationship with the doctor or the nurse. Because I got severe pain* at the same time I faced with unfamiliar health personnel and the quite terrible situation…I heard a pregnant woman was crying from pain…I quite confusion. It was complicated situation for me to understand what the doctor or the nurse said. They used the technical term that I didn't understand. It was difficulty for me." (ID.18-P12)

The stage was shifted from non-professional helpers to professional helpers or health care providers in order to receive appropriate treatment for maintaining pregnancy or preventing preterm delivery. Participants were managing the risks in order to have a healthy baby. This desired outcome seems to be a primary motivation to do whatever is necessary for minimizing the risks. However, participants were not passive recipients of care but play a very important role in the management process. The harm that might come to the baby from procedures or from taking high doses of medications during preterm labor was a major concern.. Risks and benefits needed to be considered. Making judgments about the right thing to do was necessary. If the obstetrician was wrong, participants would do what they think should be done. This was the management of "risk factor" associated with pregnancy/ illness of pregnant women with preterm labor. The motivation for playing an active management role was an overwhelming desire for a healthy baby. However, the severity of symptoms inhibited pregnant women to participate in clinical decision-making especially in the stage of assessing the clinical situation. Adequate information was a key factor of participation in clinical decision-making. In addition, the pain experienced by participants impaired the development of a rapport with health care providers. Every

pregnant woman with preterm labor spoke of waiting for a healthy baby despite the risks and of a willingness to do what was necessary to achieve this goal.

Stage 4: Taking part in clinical decision-making

According to the stage of taking part in clinical decision-making, common factors that may be of influence on the stage included personality, relationship with health care providers, cultural influence, communication skill, health care providers' attitude regarding participatory clinical decision-making, and hospital policy related to participatory clinical decision-making.

Three participants (11.54%) revealed that they did not dare to express their needs even though the health care providers were friendly. They were afraid of asking questions to their physicians. This can be seen in the participants' quotations as follows:

> "I *didn't dare to ask the doctor or nurses. I didn't have the courage*. I would like to ask but I didn't dare. They were very nice but I didn't have the courage. When they came to see me I felt a bit scared…" (ID.08-P12)

> "I was afraid to say what I concerned or I needed. *I greng-jai mhor*." (was carefully said anything that making the doctor or the nurses felt not good) (ID.21-P10)

> "Everything depended on the doctors and the nurses. I believed that they chose the best for me…*I greng-jai* that is fear of offending them (the doctor or the nurses) or causing them (the doctor or the nurses) inconvenience or looked up the doctor or the nurses with the great respect." (ID.05-P12)

The relationship with health care providers was the factor that influenced the stage of taking part in clinical decision-making as the participants said:

> "I thought that if I made a *good relationship* with the doctor or the nurse at that time, I would *dare to talk my needs* or my concerns or *share my feeling* with them." (ID21-P10)

Fourteen participants (53.85%) expressed their opinions about the Buddhist belief on the participatory clinical decision-making process. The examples of their expression are detailed as follows:

> "I believed that in *Thai society* patients must be *respect the doctor* and the nurse as they *had authority* to make a decision. Patients should *follow their suggestions without any questions*." (ID.21-P13)

> "…a good patient should *follow the doctor or the nurse suggestions*. Patient should *respect the doctor or the nurse* because they helped us to get better." (ID.09-P10)

Twenty participants (76.92%) were Buddhist. Religion belief is embedded in lives of Thai people, including the participants in this study. Buddhist belief about the law of "*karma*" provides a template for how pregnant women make sense out of their situation. Pregnant women perceived that their lives were not under their control, but under the law of "*karma*". In this study, "*karma*" was the common explanation for any suffering, happiness, and other situations that one could not understand why they occurred, such as their pain. There were two kinds of "*karma*": good "*karma*" and bad "*karma*". "*Karma*", as related to preterm labor and the situations the pregnant women in this study referred to was related to a negative occurrence; therefore it meant a bad "*karma*". Bad "*karma*" gave negative consequences, such as suffering from pain of preterm labor.

The following are accounts of how pregnant women explained their situation of pain with preterm labor, as "*karma*". Pregnant women that perceived their pain as negative "*karma*", as one participant expressed as follows:

> "Pain is my "*karma*" that I can't leave it, I must pay back for my "*karma*" (by more concerning for baby)….It was my "*karma*" that I had to *suffer with pain*. So I was reluctant to share my feeling or my troubles with the nurse. It depended upon the doctor or nurse told me I would comply with them." (ID.21-P.12)

On the other hand, pregnant women with preterm labor perceived that pain as positive, as one pregnant woman disclosed:

> "Pain is as a trigger telling me that I should *pay more attention* of my pregnancy. I worked so hard sometimes I forgot I am pregnant woman. This must be "*karma*" so that I *should avoid lifting heavy thing*." (ID.13-P09)

According to communication skill, the participants revealed that a two-way communication and partnership communication facilitated them to participate in clinical decision-making, as participants said:

> "For my thought, I would like the nurses to ask patient 'what' 'how' or 'why" more than 'yes' or 'no'. It meant that the nurse used the *open question* instead of 'close question'. They could listen to my story that might be involved in my symptom. Sometime I didn't understood the doctor and the nurse talking about my symptom by using technical terms. It was necessary to *ask them again to make sure that I understood*." (ID.12-P16)

> "I didn't like the doctor or the nurse talk to me with the authority such as you must on bed rest. You must follow the doctor's suggestions. It felt like my activity was in control of the doctor or the nurse. I didn't have the freedom. I preferred to the doctors or the nurses *talk to the patient with the sense of "we should do* that…or how we do that…it meant that we were *take responsibility together.*" (ID.23-P14)

The health care providers' attitude regarding the participatory clinical decision-making was a common factor of influence during the stage of taking part in clinical decision-making. As some participants described that if health care providers assumed that patients should take responsibility about their own health care, they should provide the opportunity for patients to take part in clinical decision-making by sharing their power with the patients and provide the time to interact with patients by listening to the patients' voice or respecting the patient as a human being. As one expectant mother disclosed:

> "My doctor told me regarding the plan of treatment and asked me about my decision or my opinion. He said that "everything depended on patients."…But some doctors in the other hospitals didn't listen to the patients. They made a decision without discussing the treatment with patients…I thought that this was dependent on doctor's attitude." (ID.15-P12)

In addition, hospital policy or health care service system was the common factor of influence on the participatory clinical decision-making process. If the hospital policy focus on encouraging the patients to participate in clinical decision-making, the health care provider will follow the hospital policy. On the other hand, the routine treatment or routine care inhibited patients to participate in clinical decision-making as one participant explained:

> "They (the doctor and the nurses) treated me as his routine work. If a patient got pain, she had to receive the same treatment. It was a *routine care of this hospital*. It meant that I could not change everything in the treatment. I should accept the doctors' suggestions." (ID.10-P9)

Stage 5: Knowing what happened

In the last stage or the stage of knowing what happened, the common factors of influence on this stage included expectation of care, information, educational background, and readiness to take part in clinical decision-making of pregnant women. Each factor's details are described as below:

> "… At that time, *I hoped that I would be receive the good care* from them (the doctor and the nurses)…" (ID.06-P4)
> According to theoretical sampling, contrast cases expressed:

> "*I expected that I would get better* two or three days, but I couldn't get better I didn't know what happened." (ID.13-P10)

> A pregnant woman, 16, 32 weeks of gestational age, the educational background was *primary school*, said:
> "…when the doctor visit me, the doctor talked to the nurses by using the *technical term. I didn't understand*…." (ID.01-P7)

> "At that time *I confuse with my pain*. *I didn't understand when the nurses talk to me*…" (ID.18-P12)

In conclusion, the process of "Coming to Know What happen: Women's Participation in Clinical Decision-making during Preterm Labor" was used to describe Thai pregnant women facing preterm labor while participating in clinical decision-making. The process consisted of two phases, pre-hospitalized phase and hospitalized phase, and five stages: 1) recognizing that something was wrong and its impact, 2) seeking help, 3) assessing the clinical situation, 4) taking part in clinical decision-making, and 5) knowing what happened. The common factors, that emerged from the data analysis, may influence the process throughout included the educational background, family relationship, severity of symptom, personality, past experience regarding preterm labor, information related to preterm labor, relationship between the patient and health care provider, communication skills, health care provider's attitude and hospital policy regarding participation in clinical decision-making, cultural influence, and expectation of care.

The process of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor" was summarized in figure 1. Each stage of the process is presented in table 3.

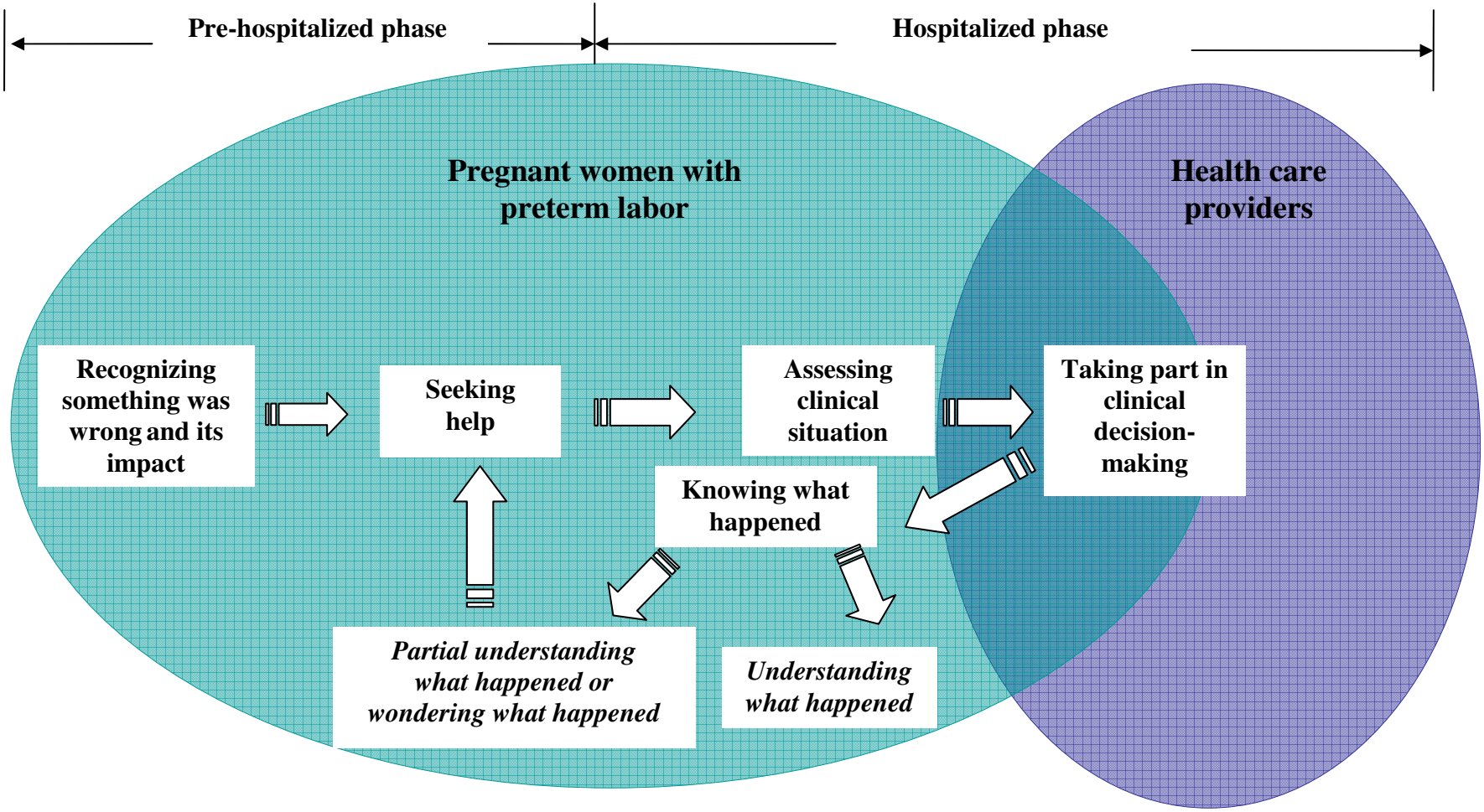

Figure 1 *Model of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor"*

Table 3

The process of participatory clinical decision-making in each phase

Phase/ Stage	Action/ Interaction strategies
Phase I : Pre-hospitalized phase	
Stage I: Recognizing something was wrong and its impact	- Perceiving abnormal symptoms - Being concerned about health status of their babies - Worrying about negative impact on family
Stage II: Seeking help	- Consulting spouse/ relatives/ friends - Deciding to go to hospital
Phase II: Hospitalized phase	
Stage III: Assessing clinical situation	- Perceiving their pain as life-threatening condition - Perceiving impact of preterm labor on their families - Seeking information about preterm labor - Making relationship with health care providers - Looking for appropriate time to interact with health care providers

Table 3 *(continued)*

Phase/ Stage	Action/ Interaction strategies
Stage IV: Taking part in clinical decision-making	- Sharing information - Asking question - Reporting difficulties - Perceiving they know their problem best - Preferring specific communication - Seeking information regarding the treatment options - Bargaining for their needs - Planning for early discharge - Making final decision with health care providers
Stage V: Knowing what Happened	*Understanding what happened* - Perceiving satisfaction with involvement in clinical decision-making - Perceiving confidence of maintaining pregnancy - Perceiving hope of healthy baby

Table 3 *(continued)*

Phase/ Stage	Action/ Interaction strategies
	Partial understanding or wondering what happened - Perceiving uncertainty of the preterm labor - Perceiving anxiety of preterm birth - Perceiving conflicts with health care providers

Discussion

This study aimed to explore the process of participatory clinical decision-making among Thai pregnant women experiencing preterm labor. The discussion is organized in the following sequence of the findings: pre-hospitalized phase and hospitalized phase.

1. Pre-hospitalized phase

This phase took place when Thai pregnant women with preterm labor perceived abnormal symptoms and before they were admitted to hospital. It encompassed two stages: 1) recognizing that something was wrong and its impact, and 2) seeking help.

Stage 1: Recognizing that something was wrong and its impact

Perceiving abnormal symptoms, worrying about the health status of the baby, and worrying about the negative impact on family were the strategies that emerged from the data in this stage.

Perceiving abnormal symptoms

Eight pregnant women (34.62%) were multipara and four pregnant women (15.39%) had experience of preterm labor or preterm birth. They perceived that uterine contractions, vaginal discharge, or decreasing of fetal movement would not occur before 37 weeks of gestation. If these symptoms occurred, they would be considered abnormal symptoms. They had the information from their experiences and from the health care providers. When they visited at antenatal care, health care providers provided health education. Pregnant women knew that the change in fetal movement did not occur even in normal pregnancy. However, eighteen pregnant

women (65.38%) were primigravida. They accessed information about preterm labor from antenatal clinic and women who experienced preterm labor. This information led pregnant women to perceive abnormal symptoms. This confirmed previous findings that the symptoms experienced in a previous episode of pregnancy or preterm labor were considered part of the perception of abnormal baselines (Moore et al., 2004; Palmer & Carty, 2006; Weiss et al., 2002). Palmer and Carty (2006) revealed that after receiving antepartum care, pregnant women sharpen their awareness of interior perception through daily self-assessments. They compared new or more intense symptoms to their baseline symptoms and felt certain about their decisions to follow antepartum help-seeking guidelines. Moreover, the finding of this study found that while pregnant women perceived abnormal symptoms, they became concerned about health status of their babies

Being concerned about the health status of their babies

Obviously, all pregnant women in this study were concerned about the health status of their babies throughout the process of participatory clinical decision-making. They perceived that preterm contractions led to preterm birth. The preterm baby was at risk of respiratory distress and the survival rate was low. Long-term care in an incubator was needed. Eye problem resulting from adverse effect of long-term oxygen treatment may occur later. The previous studies found that special problems of preterm infant included respiratory distress syndrome, intraventricular or pulmonary hemorrhage, hyperbilirubinemia, increased susceptibility to infection, anemia, neurological disorders, metabolic disturbances, and ineffective temperature regulatory mechanism (Blondel et al., 2002; Draper et al., 1999; Goldenberg, 2002; Newton, 2004). In particularly, four pregnant women (15.39%) had experience of preterm

labor or preterm birth. They worried about preterm birth occurring again. This finding is congruent with the findings from previous studies which found that pregnant women experiencing preterm labor worried about the recurrence of preterm birth and for a woman with one preterm birth the risk in a subsequent pregnancy was five times higher than women who did not have a previous history of preterm birth (Draper et al., 1999; Goldenberg, 2002; Hoffman & Bakketeig, 1984; Jijon & Jijon-Lefort, 1995). Pregnant women who experienced preterm labor or preterm birth, worried about the possible recurrence of preterm birth and the risk of delivering a preterm baby resulted in pregnant women becoming concerned about the health status of their babies. Not only pregnant women were concerned about the health status of their babies but they were also worried about the negative impact this would have on the family.

Worrying about negative impact on the family

Most pregnant women perceived that preterm contractions would have a negative impact on their families. Twenty pregnant women (84.61%) were working women in an office. Twenty pregnant women (76.92%) lived in a nuclear family. The rapid social and economic transformation has changed the lives of Thai women. Thai women have entered the workforce to increase their family income (Klausner, 1997). Sixteen pregnant women (61.54%) stayed at hospital 3-4 days. The family members made sacrifices to visit everyday and nobody look after the children at home. Pregnant women had to take leave from work which resulted in the loss of family income. Furthermore, they needed to pay a lot for treatment. They felt that this was a burden for their families. A study of Jones et al., (2002) found that preterm babies are the highest cost of health care insurance companies. The medical and economic

consequences of preterm delivery include five million hospital days per year at a cost of over five billion dollars, and these figures do not include additional costs for rehospitalization, special education, long-term care (Jijon & Jijon-Lefort, 1995; Murphy, 1993). In Thailand, the total cost for preterm babies is 2,300 million baht ($0.67 billion dollars) annually (Ministry of Public Health, 2002). Even though the partial treatment cost is cover by the social health insurance payment, a high transport fee is excluded. Pregnant women perceived abnormal symptoms, became concerned about the health status of their babies, and worried about the negative impact on their families after the "seeking help" stage was going on.

Stage 2: Seeking help

Seeking help stage started after pregnant women recognized something was wrong and its impact. Most of women with preterm contractions did not seek help until the symptoms become more intense. This finding is similar to a study by Weiss et al. (2002) which stated that pregnant women perceive a threat that leads to care-seeking. Consulting spouse/ relatives/ friends and deciding to go to hospital were the pregnant women ways to seek help.

Consulting spouse/ relative/ friends

The finding of this stage pointed out that pregnant women sought help from family members or experienced women with pregnancy or preterm labor experience more than from health care providers. Even though four pregnant women experienced preterm labor/ preterm birth, they did not consult with health care providers as their first source of information. Pregnant women preferred to share the problems with their spouses/ relatives/ experienced pregnant women because they are

close to and felt more comfortable communicating with these people than with the health care providers.

This finding is congruent with previous study of Coster-Schulz and Mackey (1998) stated that the position of health care providers was seen as superior to patients. Patients did not consult the health care providers when they had abnormal symptoms. They found a great learning resource from the women that had children and from the women that were at the same social level. In addition, a study of Bandhumedha (1998) also found that most Thai people felt that health care providers were considered authoritative people who have a more superior status than the patients, so patients preferred to discuss or consult with non-professionals. However, there were some difference between the findings of Palmer and Carty's (2006) and the present study. In Palmer and Carty's study, pregnant women did not consult family or friends to help interpret the meaning of symptoms. These women were confident in their knowledge of their body and thought that lay advice may conflict with expert guidance, complicating their decision-making. These distinctions could be a result of the difference in the context of family relationships and daily living on the part of the participants in both studies. Thus, most Thai pregnant women seek help from family members before deciding to go to the hospital. These significant persons were an important factor because they encouraged pregnant women to receive earlier treatment for preterm labor.

Deciding to go to hospital

The finding of this study revealed that sharing information with their spouse/ relative/ friend resulted in pregnant women decided to go to hospital in order to receive appropriate treatments. They worried about the health status of their babies.

They also perceived that earlier treatment was necessary and could save their babies' life. Reedy (2007) and Simpson (2004) stated that in women with suspected preterm labor, when the earlier diagnosis was made and therapeutic intervention initiated, perinatal morbidity and mortality would decrease. The level of perceived threat shaped pregnant women's decisions about symptom management through self-monitoring and self-management or seeking health care assistance. Early diagnosis of preterm labor is crucial. Diagnosis is dependent on the pregnant woman recognizing a change in her pregnancy and initiating contact with the health care providers in order to prevent preterm birth or improving fetal outcome. After pregnant women decided to go to hospital, the hospitalized phase started.

2. Hospitalized phase

The hospitalized phase started when pregnant women were admitted to the hospital. Pregnant women needed to verify their body knowledge through assessment by health care providers. This phase encompasses three stages including assessing clinical situation, taking part in clinical decision-making, and knowing what happened.

Stage 3: Assessing clinical situation

This stage consisted of perceiving their pain as life-threatening condition, perceiving the impact of preterm labor on their families, seeking information about preterm labor, making relationship with health care providers, and looking for appropriate time to interact with health care providers.

Perceiving their pain as life-threatening condition

Pregnant women perceived that preterm contractions and their pain were symptoms of preterm birth and that it was a life-threatening situation. Preterm

birth leads to low birth weight (London, et al., 2003; Moore, et al., 2004; Pompeii, et al., 2005; Wold, 1997) Infant birth weight is the determining factor of a neonate's ability to survive, and of the extent to which neurological, psychological, and physical sequelae follow (Blondel, et al., 2002; Magowan, et al., 1999; Moore, et al., 2004; Reedy, 2007; Simpson, 2004). A preterm baby is still the leading cause of perinatal morbidity and mortality in Thailand (Phupong, et al., 2004). Eighteen pregnant women (69.23%) were in gestational age of 29 to 32 weeks. They perceived that their pain resulted in preterm birth. Consequently, their baby was born too soon at the risk of low survival rate. The previous studies found that the perinatal mortality and morbidity associated with preterm birth decreased with advancing gestational age and birth weigh (Hoffman & Bakketeig, 1984; Magowan et al., 1999; Phupong et al., 2004; Pompeii et al., 2005; Reedy, 2007). Not only they perceived their pain as life-threatening condition but also they perceived the impact of preterm labor on their families.

Perceiving impact of preterm labor on their families

As mentioned above in the stage 1, pregnant women worried about the negative impact on their families. They still mentioned about this impact on their families and also related about the severity of symptoms and about unfamiliarity with health care providers in hospital situations. Fourteen pregnant women (53.85%) had no experience of hospitalization. Thus in this stage they were more worried about this impact on their families. They had to stay a long time at the hospital. Seeking information about preterm labor, making relationship with health care provider, and looking for appropriate time to interact with health care providers were needed to manage their problems.

Seeking information about preterm labor

In general, pregnant women sought information about the risks and the benefits of the preterm labor treatment option in order to participate in clinical decision-making and be guided to make a decision. The finding of this study also pointed out those pregnant women looked for information about preterm labor to share with health care providers. They revealed that information related to preterm labor was a significant factor that they needed in order to assess clinical situation. The information resources they used in this stage included pamphlets that they received from antenatal ward and from other pregnant women. The educational background was related to accessing the information. Well-educated pregnant women gained more information through reading or listening or watching television or searching from websites regarding preterm labor. Adequate information facilitated them to assess the clinical situation. In addition, the severity of symptoms influenced their ability to assess the clinical situation because their physical conditions were not stable. The findings of this study supported previous study by Deber et al. (1996) found that patients were more likely to prefer shared decision-making for non-urgent or non-life threatening conditions. Sainio et al. (2001) also claimed that a patient's physical condition, particularly regarding anxiety and shock, is regarded as an important factor hindering his/her ability to assess clinical situation. In addition, making relationship with health care providers was needed in this stage.

Making relationship with health care providers

Pregnant women in this study mentioned that a smiling face from health care providers; their expressing respect and maintaining a polite manner; saying a good word; and, on the part of the patients, following the health care

provider's suggestions were the strategies of creating a good rapport between patients and health care providers. A good relationship with health care providers could facilitate them to engage to take part in the clinical decision-making stage. The previous studies found that a major factor affecting participatory decision-making was the relationship between patient and health care providers (Bottorff et al., 2000; Henderson, 2003; Holmes-Rovner et al., 2000; McQueen, 2000; Pierce & Hicks, 2001; Sainio et al., 2001). Laitinen and Isola (1996) stated that a warm, friendly atmosphere and trustful relationship with patient made it easier for patient to co-operate with health care providers. In addition, this study found that pregnant women preferred health care providers with a sense of humor, which could relieve their tension. This finding is congruent with a study by Astedt-Kurki (2001) indicating that humor in the health care provider- patient relationship helps to establish rapport and trust, relieves anxiety and tensions, and conveys unspoken emotional messages. In addition, health care provider should emphasize on more open and collaborative relationships with patients (Hewison, 1995). The shift to new pattern of care has required a more complex set of interactions and interpersonal relations than were the case in a routinized and task-oriented operational setting (Langewitz et al., 1998). Thus, pregnant women made a good relationship with health care provider resulting in their feeling free to share their concerns and information. Not only making relationship with health care providers but also looking for appropriate time to interact with health care providers was needed in this stage.

Looking for appropriate time to interact with health care providers

Pregnant women looked for an appropriate time to interact with health care provider in order to share their problem and ask questions. The time to

communicate with the health care provider was needed. May (1995) revealed that: 1) health care providers spent little time in verbal communication with patients and that when interaction does occur, it was superficial and task oriented, 2) health care providers used a range of tactics to avoid communication, and 3) health care providers attempted to control all interaction in order to limit the quality and depth of verbal communication with patients.

The finding of this study showed that even though health care providers worked hard, pregnant women believed that health care providers would not find enough time to interact with them. Adequate time was necessary for pregnant women to share their information and discuss their problems/ needs. After assessing the clinical situation stage, pregnant women engaged in the stage of taking part in clinical decision-making.

Stage 4: Taking part in clinical decision-making

This stage included sharing information, asking question, reporting difficulties, perceiving they know their problems best, preferring specific communication, seeking information regarding the treatment options, bargaining for their needs, planning for early discharge, and making final decision with health care providers. Each strategy is discussed as below:

Sharing information

The finding of this study showed that sharing information led to pregnant women participating in clinical decision-making and understanding what happened to them. The personality of pregnant women was the common factor which would influence their sharing information with health care providers. Some pregnant women dared to talk to health care providers but they could not share information and

ask questions, report difficulties, bargain for their needs, and plan for early discharge. The final decision-making was based on the health care providers.

McKay and Smith (1993) revealed that pregnant women not only value the sharing of information, but also judge the quality of the exchanges with health care providers. When sharing occurred, the women reported feeling that they were listened to and expressed more positive emotional responses. If presented with information, the women generally participated willingly and actively in discussion and decisions, even with decisions that were initially proposed by the caregivers. Joint decisions based on shared information were well received by the women (VandeVusse, 1999). Linda (1997) also claimed that access to health information is an essential component of patient participation in one's own health care. Health care providers should not only share health information but also assess their patients' understanding of the information and the role that the patients wish their health care provider to play in the health care relationship. This can be accomplished if providers begin with their patients' perceptions, beliefs, and understanding concerning their health or illness. In addition, the sharing of information can lead to the empowerment of patients that have the ability to be active participants in their own health care decisions. If trust is developed in the patient-health care provider relationship, both the provider and patient will feel free to share concerns and information, resulting in a true health care partnership.

Asking question

Pregnant women mentioned that asking questions was the action that health care providers used to explain about the plan of care including the reason of the treatment regimen and the side effects of medication that would affect the fetal well-

being. However, some pregnant women did not dare to ask questions and felt "*greng jai*" that felt awkward to express their doubts. This attitude is a common Thai socio-cultural condition this feeling resulted in pregnant women's failure to get adequate information to be able to take part in clinical decision-making.

As Happ et al. (2007) have claimed, patients do not dare to express their needs even if the health care providers are friendly. They are afraid of raising questions with the physicians and feel shy to talk to them.

Reporting difficulties

While pregnant women received the treatment, they encountered adverse effects of the treatment such as palpitation that they could not tolerate resulting from the tocolytic drug, and constipation resulting from too long bed rest. In the laboring room, pregnant women had to separate from their families and not have other people to visit, stayed in an unfamiliar atmosphere, and looked at other pregnant women giving birth while crying in pain. Pregnant women needed to inform health care providers about their problems. Most pregnant women reported that they were bored to take bed rest. Length of stay at hospital ranged from 3 to 10 days and average hospital stay was 4.5 days. The previous studies found that pregnant women at risk of preterm birth were bored to take bed rest and some pregnant women had psychosomatic symptoms and depression (Moore et al., 2004; Palmer & Carty, 2006). Thus, too long bed rest is a factor that health care providers should be considering carefully.

Perceiving they know their problems best

Pregnant women claimed that they know their problems best. The problems were not only physical problems but also involved the psychosocial and

economic problems. Some problems health care providers did not understand especially psychosocial and economic problems. They were uncomfortable to talk to health care providers. The health care providers treated their physical problems. However, they made a decision based on the whole problems involved. The finding of this study is congruent with the study by Florin, Ehrenberg, and Ehnfors (2006) which found that patients preferred to make a final decision about their treatment because they knew their problems best.

Preferring specific communication

The findings of this study found that specific communication included two-way communication and partnership communication. Pregnant women revealed that two-way communication or using open questions helped them to share more information or their problems than closed questions. According to partnership communication, they preferred the term “We”, “Our”, “Us” because it gives a sense of working together with health care providers or not feeling under the control of health care providers. This finding is similar to the study by Epstein et al. (2004) which found that the quality of exchanging information as two-way communication was defined as active participation of the patients with their health care providers rather than one-way communication from the health care providers to the pregnant women.

Seeking information regarding the treatment options

According to the various treatment options of preterm labor, the pregnant women needed to seek information regarding those options in order to take part in clinical decision-making. The information regarding the treatment options was significant to choose the appropriate or the best treatment option. The previous studies

found that sufficient information is a prerequisite for participating in clinical decision-making (Pelkonen et al., 1998; Stower, 1992; Thompson et al., 1993). As mentioned above, information was a significant factor for pregnant women who needed to share their concerns with the health care provider. Obviously, seeking information was involved throughout the process of participatory clinical decision-making. As Beaver et al. (1996) have claimed that lack of information may have contributed to their reluctance to be more active in the decision-making process. In addition, the finding of this study found that the ability to access information was related to educational background. Well-educated pregnant women were eager to seek information by themselves and better understood the information.

Bargaining for their needs

Cahill (1996) state that bargaining does a greater degree of equality exist in patient participation level. The finding of this study found that when pregnant women had more than one option about the treatment they preferred to bargain their needs with health care providers. They perceived this action like they could take part in clinical decision-making. The previous study stated that pregnant women participated in decision-making by bargaining about the treatment or care options with health care providers when they perceived that the other treatment or care was better than they received (Harrison et al., 2003).

Planning for early discharge

Ten pregnant women (38.46%) stayed at hospital more than four days. Pregnant women disclosed that when they got better, planning for going back home should be considered. If length of stay at the hospital was too long, pregnant women worried about the mother's role to take care of children or responsibility of

housework or financial problems. Thus, planning to go back home was necessary to prevent impact on their families especially economic problems. Furthermore, bed rest for too long a time resulted in pregnant women getting bored. Astedt-Kurki's (2001), indicated that humor in the nurse-patient relationship helps to establish rapport and trust, relieves anxiety and tension, and conveys unspoken emotional messages. This type of communication can help the patient to pass the time and deflect her worries from the mundane and the routine of hospital life.

Making final decision with health care providers

According to active participation in clinical decision-making, making final decisions with health care provider was performed by pregnant women. As mentioned above pregnant women perceived that they know their problems best, so that they should make final decision with health care providers. They claimed that in making final decisions the psychosocial and economic impacts should be considered.

On the other hand, passive or compromised participation in clinical decision-making, pregnant women preferred to take their responsibilities of making final decisions on the hands of health care providers. They claimed that health care providers knew their problems best and chose the best treatment for them. This finding is congruent with a study by Willard (1996) who revealed that patients often have no option but to become dependent on health professionals to guide them. Health professionals have authority because of their knowledge of the complex hospital system, which patients do not understand. This also concurs with the patients' perspective in Avis's (1994) study, who stated that they were self-conscious about their lack of medical knowledge and the hospital routine. Hence, they forfeited the responsibility for making decisions about their care in favor of heath care providers.

Twenty pregnant women (76.92%) were Buddhist. Pregnant women were reluctant to participate in clinical decision-making for the reason that Thai social structure influences Thais, determines social and family relationships, and shapes attitudes toward illness. The Thai social system is mainly hierarchical, thus social standings and responsibilities are specifically ranked based on social status, seniority, wealth, and authority (Klausner, 1997; Suvanajata, 1976). Most of the social hierarchy is expressed through a superordinate-subordinate relationship (Podhisita, 1998). In addition to social status, gender roles are also socially constructed and clearly defined in Thai society. Women are always subordinate to men (Bandhumedha, 1998). Some pregnant women may be shy to talk to male obstetricians about some problems. Thus, they would remain quite reluctant to participate in clinical decision-making.

The health care providers' attitude was a common factor that may influence the participatory clinical decision-making. Some pregnant women indicated that health care providers assumed that patients should take responsibility for their own health care. Providing an opportunity for the patient to take part in clinical decision-making by sharing their authority, providing time to listen to the patient's voice, and respect the patient as a human being were health care providers' considerations.

In addition, hospital policy or the health care service system influenced the participatory clinical decision-making process. If the hospital policy determined this process, the health care provider should be concerned or encourage the patient to take part in the clinical decision-making. On the other hand, routine treatment or routine care inhibited the patient from participating in clinical decision-making. As Suomimen's study (1992) revealed, women patients are willing to participate more

actively in their own care, but this is sometimes not allowed in the health care system. The patients believed that they had to take more responsibility for their own care, but the possibilities of doing so were few.

After taking part in clinical decision-making, the stage of knowing what happened started.

Stage 5: Knowing what happened

The outcome or the consequence of this process of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor." This last stage consisted of understanding what happened and partial understanding of what happened or wondering what happened, as the details were discussed as follow:

1. Understanding what happened

The fulfillment of taking part in clinical decision-making resulted in pregnant women understanding what happened. Perceiving satisfaction with involvement in clinical decision-making, perceiving confidence of maintaining pregnancy, and perceiving hope of a healthy baby were the perceptions of pregnant women who understood what happened.

Perceiving satisfaction with involvement in clinical decision-making

According to pregnant women facing preterm labor who understood what happened, they felt satisfied with their involvement in clinical decision-making. This study supports the study of Harrison et al. (2003) found that women who involved in health care decision satisfied with the care during a high risk pregnancy. In this study found that adequate time to interact with health care providers and understandable information were central to the pregnant women's involvement in care

decision and their satisfaction with their prenatal hospitalized experiences. This finding is consistent with previous studies that link pregnant women's sense of control, decision-making involvement, and satisfaction with maternity care (Hogston, 1995; Laslertt, Brown, & Lumley, 1997; Lindsey & Hartrick, 1996; Proctor, 1998).

Perceiving confidence of maintaining pregnancy

Pregnant women perceived that their taking part in clinical decision-making resulted in their understanding what happened and knew that what they should do in order to maintain their pregnancy. Pregnant women's expectations outcome achieved led them to have a confidence to maintain their pregnancy. The finding of this study showed that not only pregnant women were satisfied with their involvement in decision-making but also had the confidence of maintaining pregnancy. If pregnant women understood what happened, they would know how they should manage subsequent issues regarding preterm labor symptoms at home after being discharged from the hospital. This finding is similar to the previous study which found that expectant mothers participated in decision-making had a confidence to prevent preterm birth (Pelkonen et al., 1998).

Perceiving hope of having a healthy baby

All pregnant women revealed that they carefully looked after themselves in order to have a healthy baby. A health baby was their hope. They attempted to learn what they should do and what they should avoid doing in order to have a healthy baby. When pregnant women participated in clinical decision-making, they could know what happened. Consequently, they would raise their hope of having healthy baby. Pregnant women had a confidence of maintaining pregnancy until term which contributed to meet their hope of full term healthy baby. The finding is

congruent with the study by Palmer and Carty (2006) which found that pregnant women actively taking part in decision-making of their own health care resulted in their knowing what they should do and avoids doing to increase the chances of delivering healthy babies. In addition, Suguin, Therrien, Champagne, Larouche (1989), Sines (1995) and Simkin (1996) claimed that health care providers have encouraged women to be full partners in decisions about their giving birth, and women's active participation in birth is related to their long-term positive memories, self-images, and ability to mother effectively. If pregnant women experience this, powerful and positive emotions would be the result in their responses to the birth experience and their view of their strengths.

However, some pregnant women failed to take part in clinical decision-making or only partially participated in clinical decision-making. They partially understood what happened or wondered what happened.

2. Partial understanding or wondering what happened

According to their partial understanding of what happened, they perceived uncertainty of the preterm labor, anxiety of preterm birth, and having conflicts with health care providers.

Perceiving uncertainty of the preterm labor

Pregnant women perceived that a tocolytic drug could relieve their pain that resulted from uterine contractions. After taking medication, their pain did not relieve like their expected time. Consequently, uncertainty of the preterm labor would occur. This finding of this study is similar to the study by Weiss et al. (2002) stating that women experiencing the onset of preterm labor perceived the uncertainty of preterm symptoms. Three pregnant women (11.54%) experienced a readmission.

and perceived the uncertainty of preterm labor. However, they did not dare to ask health care providers or were not ready to take part in clinical decision-making because of lack of information about preterm labor.

Perceiving anxiety of preterm birth

Pregnant women expected that the appropriate treatment would help them to maintain their pregnancy. Three pregnant women (11.54%) had experience of readmission at the same hospitals. Four pregnant women (15.39%) had experience of preterm labor or preterm birth. They worried about preterm birth because they did not understand what happened to them and what they should do and what they should avoid doing in order to prevent preterm birth. They did not dare to ask health care providers. The outcome of treatment did not achieve their expectations which resulted in their worrying about the possible recurrence of preterm birth. Hoffman and Bakketeig (1984) found that a woman with one preterm birth experience has twice the risk for another, with three or more preterm birth. The risk in a subsequent pregnancy was five times higher than women who did not have a previous history of preterm birth.

Perceiving conflicts with health care providers

Pregnant women expected that health care provider would perform in the same way as their expectations of treatment or outcome. When pregnant women did not achieve their expectations, they perceived conflict with their health care providers. The pregnant women did not dare to talk to them. Some of the participants in this study followed the health care provider's judgments even if they had inner conflict. This study is congruent with the study by Thompson (2002) stating that pregnant women had conflicts with health care providers by accepting the

obstetrician's plan of care without asking questions or stating their preferences and seeking other settings. The findings of this study found that some pregnant women who had conflicts with health care providers resulted in seeking other helpers or transferring to other hospitals. In this case the process of participatory clinical decision-making would recur as shown in figure 1.

In conclusion, the evolving model of "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor" emerging from the study illustrated that risk perception, needed information, help seeking and understanding were major concepts existing throughout the process. Acknowledging that preterm labor might be a life-threatening condition of the baby and considering the impact of the preterm labor on the family resulted in pregnant women gathering information about their problems, making a relationship with health care providers, and looking for appropriate time to interact with health care providers in order to participate in clinical decision-making. The pregnant women's participation was gradually developed from receiving information, consultation, and negotiation to active participation. Some pregnant women put the responsibility of their health in the hands of health care providers (Biley,1992). Some pregnant women consulted the health care providers or bargained for their needs. In addition, some pregnant women actively participated in the clinical decision-making process by sharing information and took part in making a decision.

In addition, majority of the women in this study had been participating at the level of consultation. the process of pregnant women participation in clinical decision-making was driven by personal experience of preterm labor/ preterm birth, educational background, family support of pregnant women, pregnant women- health

care providers' relationship, and Thai cultural influence. From personal experience of preterm labor/ preterm birth, not only pregnant women recognized that something was wrong but also forced them to acquire urgent assistance from health care providers to save the baby's life. The educational background shapes a cognitive skill of pregnant women in making a decision based on their knowledge. Well-educated pregnant women resulted in the capability to raise a question and seeking information from various resources.

Furthermore, family support of the women and their relationships with health care providers were significant factors that influenced on the process of pregnant women participating in clinical decision-making. The family members were the people pregnant women trusted and felt comfortable to consult their problems. According to the relationship with health care providers, pregnant women perceived that health care providers were authorized persons and had a superior status than the patients because they had higher levels of education. They were busy and did not have enough time to interact with pregnant women. The Thai pregnant women were often viewed as inferior, with less negotiating power because of the traditional notion in Thai society that the health care providers have an authority. The patients are expected to respect, comply with, obey, and honor the health care providers by following their suggestions (Boonmongkol, 2000; Suphametaporn, 1999).

Moreover, Thai pregnant women's view of their illness was influenced by Buddhist belief that things and events are beyond individual control and that nothing can be done to prevent or escape from them (Podhisita, 1998). Consequently, the Thai pregnant women were more likely to accept illness or unpleasant experience as the product of their own "fate". Thus, they accepted the health care providers without

negotiating power. Giving respect to the health care providers, pregnant women did not reject their suggestions but tended to follow their health care providers judgments even if they had inner conflict. According to the reasons that mentioned above, most of Thai pregnant women passively participated in clinical decision-making. However, the explicit factors that may facilitate the process of participatory in clinical decision-making included personal experience of preterm labor/ preterm birth, family support, and a good relationship between pregnant women and health care providers. On the other hand, the factors that may inhibit the process encompassed low-educational background, lack of information, and Thai cultural influence among the pregnant women.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

This final chapter presents a conclusion regarding the findings, recommendations that derive from the findings, and the limitations of the study.

Conclusion from the findings

The purpose of the study was to explore the process of participatory clinical decision-making among Thai pregnant women experiencing preterm labor by using a grounded theory approach. A constant comparative analysis was used to identify the components of the evolving model. The model that emerged from the study is "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor."

The basic social process "Coming to Know What Happened: Women's Participation in Clinical Decision-making during Preterm Labor." is a process in which Thai pregnant women participate in clinical decision-making while they are facing the onset of preterm labor and hospitalization. They could share information, power, and their concerns with other people, i.e. spouse, mother, relatives, friends, and health care providers. The pregnant women had been participating in clinical decision-making in order to maintain pregnancy. The participants revealed that participation in clinical decision-making was a good opportunity to learn about what happened on their pregnancy and they could manage their problems by themselves. This model encompasses two phases, pre-hospitalized phase and hospitalized phase,

and five stages: recognizing that something was wrong and its impact, seeking help, assessing the clinical situation, taking part in clinical decision-making, and understanding what happened. Each stage was triggered by an important moment of realization in which the pregnant women perceived something was happening in their biopsychosocial changes and that they needed to interact with health care providers. Stage 1: Recognizing that something was wrong and its impact: This stage was triggered and started when the women perceived that something was wrong. Then they suspected preterm labor. The duration of stage1 depended on the severity of their conditions, from 1 to 3 days. Stage 2: Seeking help: This stage occurred when the pregnant women sought help. The duration of stage 2 was from 1 to 2 days. Stage 3: Assessing clinical situation: This stage was triggered after the pregnant women decided to go to the hospital. The duration of stage 3 was from 1 to 2 hours. Stage 4: Taking part in clinical decision-making: This stage was triggered when the pregnant women took part in clinical decision-making. The duration of stage 4 was from 1 to 3 days. Stage 5: Understanding what happened: This stage began when the pregnant women understood what was happening to them. The duration of stage 5 was from 3 to 4 days.

During stages 1 to stage 3, the needs and concerns of the pregnant women focused on the survival of the babies, but in stage 4 and stage 5 they shifted their focus to the prevention of preterm labor, family, and economic impacts. The strategies of information seeking by asking questions and reporting their problems and needs were utilized to participate in decision-making. The pregnant women could learn to know what had happened to them and how to manage their problems by themselves. During stage 4 and stage 5, the strategy of creating a relationship with

the health care providers and sharing information and feelings was utilized for engaging in their own care. Obviously, concern for their babies and the impacts on their families emerged throughout the process. On the other hand, if the pregnant women wondered what had happened to them, the process of "Coming to Know What Happened" would occur again. However, the pregnant women easily engaged in this process afterwards. The factors that influenced the process could be divided into pregnant woman's factors, health care provider's factors and social factors. The pregnant woman's factors: educational background, perceived severity of symptom, personality, past experience regarding preterm labor, receiving information about preterm labor, and expectation of care. The health care provider' factor: attitude regarding participation in clinical decision-making and hospital policy. The social factors: family relationship, health care provider relationship, communication skill, and cultural influences. Thai pregnant women utilized a basic social process of "Coming to Know What Happened" to carry on their participation in clinical decision-making.

Recommendations based on the findings

The recommendations based on the findings were present implications of the research findings, recommendations for further research, and contribution to nursing theory/ knowledge development. The findings from this study resulted in an evolving model of the participatory clinical decision-making process among Thai pregnant women experiencing preterm labor. This model provides implications and recommendations as follows:

1. Implications of the research findings

1.1 Providing information regarding abnormal signs and symptoms of pregnancy is needed for pregnant women to early detect preterm labor especially primigravidarum pregnant women. The treatment options of preterm labor when pregnant women are admitted to in-patient wards are also needed to discuss with pregnant women and their families. Listening to the voices of pregnant women and their families provides essential knowledge for health care providers to guide clinical practice.

1.2. Acknowledging the overriding and consistently voiced concern for fetal physiological well-being is a call from pregnant women which is needed. Obviously, after a diagnosis of preterm labor is made, care of the woman and fetus is focused on maintaining the pregnancy to prolong the time for intrauterine development. The pregnant women concerned themselves about the health status of their babies. Thus, providing information regarding fetal well-being should be considered.

1.3. Constructing friendly relationship with pregnant women is needed to encourage pregnant women to participate in clinical decision-making. The comprehensive answers to pregnant women are also needed so that pregnant women can feel free to ask any questions and share concerns. In addition, providing an environment that is emotionally secure for the pregnant women is considered. The basis of patient participation requires trust and security. Therefore, health policy in Thailand needs to be reformed; there is a need to develop greater participation, encouragement, and collaboration in maternity care practices.

1.4 Providing time to interact with pregnant women is necessary. The pregnant women can disclose their problems and their needs by using a two-way communication. A change in the health care providers' attitude toward the care of the pregnant women in preterm labor in Thailand is needed in order to improve communication between the health care provider and pregnant women especially for pregnant women at a lower educational background and social status. It is necessary, from the pregnant women's point of view, that their health care providers are open-minded and respectful of their opinions about their illness.

1.5 Encouraging their spouses to support pregnant women to participate in clinical decision-making should be considered. Providing information about preterm labor for their spouses during follow up at antenatal care is needed. Pregnant women prefer to discuss or consult with non-professionals, particularly their spouses and experienced pregnant women.

1.6 Making pregnant women ready to participate in clinical decision-making. In particular, Thai women dare not to talk to health care providers. Friendly communication and a warm relationship should be established throughout their hospitalization. Providing not only information but also time for interacting with pregnant women and sharing power by listening to the patients' voice are necessary. In particular, the less-educated women, simplifying the information and avoiding using technical terms when talking to the pregnant women, are necessary. In addition, strategies that encourage pregnant women to participate in clinical decision-making are based on influential factors such as, duration, and expected outcome.

1.7 Designing an educational program in antenatal care that can assist pregnant woman in seeking help earlier in order to receive appropriate treatment, thus

resulting in decreasing preterm delivery. Improved education that would enable pregnant women and health care providers to recognize and interpret the subtle signs of preterm labor are important. Providing enough information to permit safe and informed choices to be made whilst avoiding excessive information that might confuse or frighten the women is also necessary. The intervention of education programs by paying attention to spouse and family members is needed. While pregnant women are hospitalized, an intervention program that is designed for encouraging pregnant women to take part in clinical decision-making is needed. This process contributes to pregnant women preventing preterm delivery because in this way they can manage their preterm labor symptoms by themselves after being discharged from the hospital. Thus, advising pregnant women to seek care earlier for suspected preterm labor is significant; earlier diagnosis and therapeutic intervention initiated in order to prevent preterm birth. Moreover, by actively participating in clinical decision-making they would satisfy themselves with the care, have confidence in maintaining their pregnancy, and have a hope of giving birth to a healthy baby. Active participation also resulted in pregnant women learning to know what happened and how they can manage their problems. Consequently, preventing preterm birth and achieving the baby's well-being will be assured.

In conclusion, the processes that emerged from the findings can apply to develop or determine the intervention in order to achieve the expected outcome or active participation in clinical decision-making.

2. Recommendations for further research

Recommendations for further research based on this study are presented in detail as follows:

2.1 Developing an instrument to measure the level of participatory clinical decision-making based on the findings of this study is needed. It is recommended that further research will be conducted by testing the model of participatory clinical decision-making.

2.2 Requiring further investigation of each category that emerged from this process i.e., severity of symptoms versus cultural influences regarding the participatory clinical decision-making process. In the cases of wondering what happened also requires further study by exploring what target populations perceive regarding clinical decision-making. In addition, some open codings that emerged from the findings were excluded from this model by using theoretical sampling and constant comparative analysis. Further study may be able to clarify these codings by exploring this process in other groups or other settings. The results of the study can guide health care providers in assessing clinical situation of pregnant women and in encouraging them to participate in the clinical decision-making process. Future research will use substantive model as a basis for understanding of the participatory clinical decision-making process of pregnant women in general.

2.3 Conducting the participatory clinical decision-making process from the perspective of health care providers that could be increase the understanding of this process is necessary. This study was conducted from the perspective of pregnant Thai women experiencing preterm labor. In addition, such study needs to be conducted in every part of Thailand with diverse groups of pregnant women, for example, in private hospitals, a different context in this study. Finally, health care providers need appropriate instruments for assessing readiness of Thai pregnant women to participate in clinical decision-making.

3. Contribution to nursing theory/ knowledge development

This study provides an evolving model, entitled “Coming to Know What Happened,” which explains the participatory clinical decision-making process among Thai pregnant women experiencing preterm labor. The model contributes to practical nursing knowledge that can be used to develop interventions for encouraging Thai pregnant women to participate in clinical decision-making.

Limitations of the study

The purpose of this study was to explore the participatory clinical decision-making process among Thai pregnant women experiencing preterm labor that were hospitalized at two public hospitals in Bangkok. The findings may or may not be applicable to all Thai pregnant women in preterm labor that are hospitalized at other hospitals or that live in other areas because of demographic factors of pregnant women and health care service system in particularly private settings. Therefore, the findings need to be interpreted carefully when applied to the rural area hospitals and private hospitals. However, the substantive model in this study will be useful for developing pregnant women experiencing preterm labor in a similar context especially in public tertiary hospitals at Bangkok.

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Appendix A.

Initial Interview Guideline

(English Version)

Participants will be asked the following questions. Not all probes will be asked, but they will be used based on the information gained during the interview.

Tell me about your experience of participatory decision-making in treatment and nursing care.

General Probing Questions:

1. How do you feel about…?
2. What are your thought/ reaction to…?
3. How that make you feel…?
4. What do you mean by…?
5. Can you tell me more about…?
6. What make you feel…?
7. When does…occur? What make…occur?
8. Any thing you want to tell me or want to add?
9. What do you think about…?
10. Could you tell me why…?

Possible probes:

1. Tell me about your preterm labor during pregnancy?
2. How do you receive the treatment and nursing care?

3. What opportunities do you have to participate in the decision-making about your treatment and nursing care?

4. How do you feel about the outcome of decision-making in your treatment and nursing care?

5. Who is involved in the decision-making about your treatment and nursing care?

6. How are other people involved in the decision-making about your treatment and nursing care?

7. What are the influences in your decision-making about your treatment and nursing care?

8. What do you think about your participation in the decision-making of treatment and nursing care?

Appendix B.

Initial Interview Guideline

(Thai Version)

ผู้วิจัยจะถามคำถามกว้าง ๆ เพื่อให้อาสาสมัครมีโอกาสถ่ายทอดประสบการณ์จากมุมมองของตนเองมาก ที่สุด สำหรับคำถามเจาะลึกนั้น ผู้วิจัยจะเลือกถามเพียงบางคำถามขึ้นอยู่กับข้อมูลที่ได้รับจากการสัมภาษณ์

คำถามกว้าง ๆ กรุณาเล่าเกี่ยวกับประสบการณ์การมีส่วนร่วมในการตัดสินใจรักษาพยาบาลในช่วงระยะตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนด

ลักษณะคำถามเจาะลึกทั่วไป

1. ท่านรู้สึกอย่างไรเกี่ยวกับ.....
2. ท่านมีความคิดหรือปฏิกิริยาอย่างไรเกี่ยวกับ.....
3. สิ่งนั้นทำให้ท่านรู้สึก.....
4. ท่านหมายถึง.....
5. กรุณาเล่าให้ฟังอีกนิดเกี่ยวกับ.....
6. อะไรทำให้ท่านรู้สึก.....
7. .....เกิดขึ้นเมื่อไร อะไรทำให้เกิดขึ้น.....
8. มีอะไรที่คุณต้องการเล่าให้ฟังหรือต้องการเพิ่มเติม.....
9. ท่านคิดอย่างไรเกี่ยวกับ.....
10. ท่านบอกได้ไหมว่าทำไม.....

ตัวอย่างคำถามเจาะลึก

1. กรุณาเล่าเกี่ยวกับภาวะเจ็บครรภ์คลอดก่อนกำหนดที่เกิดขึ้นในระยะตั้งครรภ์
2. ท่านได้รับการรักษาพยาบาลอย่างไร
3. ท่านได้มีโอกาสร่วมในการตัดสินใจในการรักษาพยาบาลอย่างไร
4. ท่านรู้สึกอย่างไรต่อผลของการตัดสินใจในการรักษาพยาบาล
5. ใครบ้างที่มีส่วนในการตัดสินใจในการรักษาพยาบาล
6. บุคคลดังกล่าวมีส่วนในการตัดสินใจอย่างไร
7. อะไรที่มีส่วนช่วยในการตัดสินใจในการรักษาพยาบาล
8. ท่านคิดว่าท่านควรจะได้มีส่วนร่วมในการรักษาพยาบาลอย่างไร

Appendix C.

Demographic Form

(English Version)

Interviewing Form No…

Interview Date……

Duration of interviewing…… time from ……..to……

Interviewing Record Form of Participatory Clinical Decision-Making Process among Thai Pregnant Women with Preterm Labor

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Name……...Age…….

Religion…….Educational background……Occupation……..

Number of sibling……Order of offspring…….Family income……baht/month

Marital status…….. Number of children……

Type of family…… (Nucler/ Extended) Number of person in family……...

Address…….

Telephone number……

Obstetrics history……..

……..

Gravidity…….Gestational age…… Hospital's Name ……

Length of hospital stay …….Readmission…….(Yes/No)

Complication……

Diagnosis……..

Treatment…….

General appearance…….....

……..

……

…….

Husband's background

Age……..Educational age…….Occupation……

Order of interviewing…… Next time Interviewing Date ……...

Place of interviewing ……..

Situation during interviewing…….....

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……..

……..

Case conclusion

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…….

……..

Plan for next interviewing……

……..

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…….

Appendix D.

Demographic Form

(Thai Version)

แบบสัมภาษณ์ชุดที่……..

วันที่สัมภาษณ์……

เวลาที่ใช้ในการสัมภาษณ์.....เริ่มเวลา.....สิ้นสุดเวลา.....

แบบบันทึกการสัมภาษณ์ เรื่องกระบวนการการมีส่วนร่วมในการตัดสินใจทางคลินิก

ในไทยหญิงตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนด

(Participatory in Clinical Decision-Making Process among

Thai Pregnant Women with Preterm Labor)

ชื่อ…….. อายุ……...

ศาสนา……ระดับการศึกษา……อาชีพ……..

จำนวนพี่น้อง.....คน เป็นบุตรคนที่..... รายได้ของครอบครัว…… บาทต่อเดือน

สถานภาพสมรส……. จำนวนบุตร…….คน

ลักษณะครอบครัว…… (เดี่ยว หรือ ขยาย) จำนวนบุคคลในครอบครัว……..คน

ที่อยู่……..

เบอร์โทรศัพท์…….....

ประวัติการตั้งครรภ์และการคลอด……..

ครรภ์ที่…… อายุครรภ์……...เข้ารับการรักษาที่โรงพยาบาล…….

ระยะเวลาที่เข้ารับการรักษา……เคยเข้ารับการรักษา……(เคย/ไม่เคย)

ภาวะแทรกซ้อนที่พบ……

วินิจฉัยโรค……

การรักษา……..

ลักษณะทั่วไป……

……

……

……

……

……

ข้อมูลของสามี

อายุ.....ระดับการศึกษา.....อาชีพ.....

สัมภาษณ์ครั้งที่……นัดสัมภาษณ์ครั้งต่อไปวันที่……..

สถานที่สัมภาษณ์……

สถานการณ์ขณะสัมภาษณ์……

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สรุปการสัมภาษณ์…….

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แผนการสัมภาษณ์ครั้งต่อไป

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Appendix E.

Human Subject Protection

(English Version)

Participatory Clinical Decision-making Process among

Thai Pregnant Women with Preterm Labor

Researcher: Prapa Rattasumpun

Doctoral student, Faculty of Nursing

Prince of Songkla University

Tel. (02) 9878197 (home)

Purpose and Significance of the Research

The purpose of this study is to describe the experiences of pregnant Thai women with preterm labor and how they think and feel about their participatory clinical decision-making. This study will be significant for a better understanding of the experiences of pregnant Thai women with preterm labor regarding their participating in clinical decision-making. The information which you give will be able to contribute to nurses and other health care providers to give more effective care for the pregnant women with preterm labor. In addition, the nursing students should be equipped with the experience of pregnant Thai women with preterm labor to enable them to provide appropriate nursing care.

Research Procedures

The researcher will meet and interview you at least 2 times. Each interview will last approximately 1- 1½ hours. The interview is related to questions regarding your experiences of participatory clinical decision-making during pregnancy with

preterm labor. The personal information from the health record is collected after your permission.

The researcher will record the interview with the audio-tape. Portion of the tape recording will be transcribed to written form. The information from the interviews and health records will be handled as confidential. Your name will not be on the tape or on the written transcription. Audio-tapes and written records will be destroyed at the end of the study. During your interview, you are free to refuse to answer any questions and to withdraw from the study at any time. The interview can be stop at any time you want. You will be given 200 Baht as transportation fee and participation in the study. During interview, researcher will not share the opinion that influencing your participatory clinical decision-making process.

……..

Signature of the researcher

Participant's Statement

The study information including objectives, procedures, data collection, and presentation has been explained by the researcher. I also understand about my rights regarding confidential, refusing to answer the question, and withdrawing at any point in the process. I am willing to participate in this study.

…….

Signature of the participant

Date……..

Copy: Participant

Researcher

Appendix F.

Human Subject Protection

(Thai Version)

กระบวนการการมีส่วนร่วมในการตัดสินใจทางคลินิกในหญิงไทยตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนด

ผู้วิจัย: ประภา รัตตสัมพันธ์

นักศึกษาปริญญาเอก สาขาการพยาบาล

คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์

โทร (02) 9878197 (บ้าน)

วัตถุประสงค์และประโยชน์ของการวิจัย

วัตถุประสงค์ของการวิจัยครั้งนี้ มุ่งเน้นที่จะบรรยายถึงการที่หญิงไทยที่ตั้งครรภ์และมีภาวะเจ็บครรภ์คลอดก่อนกำหนด มีประสบการณ์การมีส่วนร่วมในการตัดสินใจทางคลินิก ประโยชน์ที่จะได้รับจากการศึกษาครั้งนี้คือทำให้เข้าใจเกี่ยวกับประสบการณ์การมีส่วนร่วมในการตัดสินใจทางคลินิกของหญิงไทยที่ตั้งครรภ์และมีภาวะเจ็บครรภ์คลอดก่อนกำหนดดีขึ้นข้อมูลที่คุณให้จะช่วยให้พยาบาลและบุคลากรทางด้านสุขภาพที่ให้การดูแลหญิงตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนด สามารถให้การช่วยเหลือที่ดีแก่หญิงตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนดได้ตรงกับความต้องการ นอกจากนี้ยังเป็นแนวทางในการสอนนักศึกษาพยาบาลให้เข้าใจถึงความต้องการของหญิงไทยในขณะตั้งครรภ์ที่มีภาวะเจ็บครรภ์คลอดก่อนกำหนด เพื่อวางแผนการพยาบาลที่มีคุณภาพต่อไป

ขั้นตอนของการวิจัย

ผู้วิจัยจะบันทึกการพูดคุยสัมภาษณ์กับคุณด้วยเทปบันทึกเสียง และถอดเทปการสนทนา ข้อมูลที่ได้รับจากการสัมภาษณ์และแบบบันทึกสุขภาพของคุณจะถือว่าเป็นความลับ ไม่มีการเปิดเผยชื่อจริงของคุณในข้อมูล เทปและเอกสารที่ใช้ในการบันทึกการสัมภาษณ์ จะถูกทำลายเมื่อการวิจัยครั้งนี้สิ้นสุดลง และตลอดระยะเวลาที่คุณถูกสัมภาษณ์ คุณสามารถที่จะปฏิเสธการตอบคำถามที่คุณไม่ต้องการจะตอบและสามารถขอให้หยุดการสนทนาได้ทุกเวลา นอกจากนี้คุณยังสามารถถอนตัวจากการให้ข้อมูลได้ตลอดเวลา การสัมภาษณ์ผู้วิจัยจะมอบเงินจำนวน 200 บาทแก่คุณเพื่อเป็นค่าเดินทางในการให้ข้อมูล ซึ่งเป็นประโยชน์ต่อการวิจัยครั้งนี้ และในระหว่างการสัมภาษณ์ผู้วิจัยจะไม่แสดงความคิดเห็นใด อันจะส่งผลต่อกระบวนการการมีส่วนร่วมในการตัดสินใจทางการรักษาพยาบาลของท่าน

.....ลายเซ็นของผู้วิจัย

ใบยินยอมเข้าร่วมโครงการวิจัย

ข้าพเจ้าได้รับการอธิบายถึงวัตถุประสงค์ ขั้นตอนของการศึกษาวิจัย และขั้นตอนในการเก็บรวบรวมข้อมูล ตลอดจนการนำเสนอข้อมูลเกี่ยวกับการศึกษาวิจัยที่กล่าวมาแล้ว รวมทั้งได้รับการชี้แจงสิทธิในการที่ผู้วิจัยจะไม่เปิดเผยชื่อผู้เข้าร่วมวิจัยเป็นรายบุคคล สิทธิที่จะไม่ตอบคำถาม และสามารถบอกเลิกการเข้าร่วม ในงานวิจัยได้ทุกขั้นตอน ข้าพเจ้ามีความสมัครใจที่จะเข้าร่วมในการวิจัยครั้งนี้

ลงชื่อผู้เข้าร่วมวิจัย……

…….. (ตัวบรรจง)

วันที่……...

สำเนา: ผู้เข้าร่วมในการวิจัย

แฟ้มของผู้วิจัย

Appendix G.

Example of participant's quotation

ID.01

A pregnant woman 16 years old with G_1P_0, 32 weeks of gestational age, said:
"On the last Friday morning I felt like false labor pain as my previous pregnancy. I knew that it was normal. Two day later I felt my baby movement decreased. I worried the baby may be jeopardize. Then, I felt like labor pain but I was not sure and knew that it was abnormal signs."(ID.01-P5)
"I called my friend who had preterm birth experience. I told her about my pain and the fetal movement decreasing. She told me it was not so good and suggested me go to hospital. After calling her, I changed my dress in a hurry for preparing to go to hospital. I called my spouse to come back and go to hospital with me. I decided to go to hospital because of the safety of my baby." (ID.01.P8)
"My husband needed to take care of my mother who had heart disease, but he visited me every afternoon. I looked at him and saw he was so tired. Today, I felt better, and I would like to ask the doctor could I go back home. I would be so happy if he ordered to discharge me."(ID.01-P9)
"I just stopped working from my office since the last three months. So I paid the medical expenses by myself… After giving birth, I planned to continue studying… My spouse had not enough money to pay the medical expenses. I consulted my problem with the nurse." (ID.01-P7)

ID.02

A pregnant woman 20 years old with G_1P_0, 35 weeks of gestational age, said:
"I got abdominal pain then I called my husband. He suggested me going to see doctor. I agreed with him". (ID.02-P3)
"I worried about my baby's health. I hope that my baby is healthy". (ID.02-P4)
"When I saw pictures of other babies' deformity from the television or anywhere, I feared that my baby would be like that." (ID.02-P8)
"I would like to have a healthy baby. If I gave birth to preterm baby, I will be suffering all my life". (ID.02-P10)

ID.03

A pregnant woman 27 years old with G_1P_0, 29 weeks of gestational age, said:
"I heard from my friend. She told me that if I gave birth more before the expected date of delivery, the chance of baby was mental retardation more increasing. I tried to maintain pregnancy for giving birth near term to prevent mental retardation of baby. I worried my baby. I hoped that my baby was normal." (ID.03-P12)

"I told my pain with my spouse. He wondered about my pain because of just only twenty-nine weeks of gestational age. He told me to go to hospital. Then, I decided to go to hospital with him." (ID. 03-P11)
"I told doctor about my symptoms and he told me about the therapeutic regimen. Some problems I had not talked with him such as my financial problem or the limitation of my family. My spouse had passed away and I earn money for my family alone. So he could not know really problem. When he suggested me I needed to consider my problem again. Finally, I made the decision by myself. Then, I told my decision to doctor." (ID.03-P12)

ID.04

A pregnant woman 31 years old with G_2P_1, 31 weeks of gestational age, said:
"The nurses took the blood pressure, fetal heart sound, uterine contraction…and so forth. It was the routine of their work. Some nurses didn't have the time to listen to the patients' problems. They were very busy." (ID.04-P8)
"After receiving drug for relieving uterine contractions I felt palpitation. That night I could not sleep I asked the nurse about the effect of drug on the baby. I was anxious the increasing of my heart rate and my baby could tolerate or not. If I my pain relieved, my baby could survive or not. I told the nurse about my problem and she decreased the rate of drug. Then, I got better." (ID.04-P9)
"…When the doctor told me the treatment, I would consider the cost and benefit because I paid medical expenses by myself. I stayed at hospital I could not earn money. I was afraid that I had not enough money to pay for medical expenses. I told the nurse about my financial problem." (ID.04-P8)
"The doctors suggested leaving for working couple weeks. I thought that it spent a long time. I told him I got better. Could I leave for one week? I was afraid of the impact of my business." (ID.04-P5)
"I waited for the nurse who worked in the last night shift. I would like to ask her about my some problems that I thought that she was only one who understood me. She was very good nurse with friendly." (Pregnant woman ID.04-P6)

ID.05

A pregnant woman 32 years old with G_1P_0, 34 weeks of gestational age, said:
"My relatives had experiences of preterm labor. She told me that she readmitted three times for receiving drug to inhibit uterine contractions. However, finally she gave birth with premature baby and her baby was too small to survive. I worried about my baby. I prayed for my baby every night."(Pregnant woman ID.05-P7)
"I imagined… if I would be having a preterm baby. I and my spouse would be difficulty. I have not adequate money to cure him…. I felt sad when I saw my niece, she was born when her mother with only thirty weeks of gestational age. She is mental retardation. I would be suffer as my brother's family if I encounter that problem (premature baby)." (ID.05-P10)
"I heard from my friend about the side effects of drug. I was afraid that I could not tolerate the side effects. I asked the nurse if I felt not so good how I do." (Pregnant woman ID.05-P5)

"…My educational level was only primary school, so I could not involve in making a decision that is the responsibility of the doctors and the nurses. They were the expertise. I should follow their suggestions. I lacked of information to participate in making a decision with them. Everything depended on the doctors and the nurses. I believed that they chose the best for me…I *greng-jai* that is fear of offending them (the doctor or the nurses) or causing them (the doctor or the nurses) inconvenience or looked up the doctor or the nurses with great respect."(ID.05-P12)

ID.06

A pregnant woman 22 years old with G_1P_0, 32 weeks of gestational age, said:
"Once I felt abdominal pain like cramp pain during the menstrual period, I worried about the baby. That night, I could not sleep. I had read from the maternal magazine when uterine contracted the oxygen in my baby's blood would be decreased. I feared that my baby might be dead." (ID.06-P5)
"For the first admission, my mother and my husband made sacrifices to visit me everyday. Sometimes my husband would leave work to visit me. My mother and my husband were tired. Moreover, my home was far from here and they needed to wait for the bus for quiet a long time." (ID.06-P10)
"I obtained information about the side effect of drug from the leaflet that the nurse gave me after receiving the drug. I had some points in leaflet that I didn't understood. I asked the nurse. She explained me and I understood." (ID.06-P8)
"I was afraid of readmission because I have abdominal pain again after the doctor discharged me two days." (ID.06-P14)
"This was the second time that I readmitted with the abdominal pain or the same problem as the first time. The first time I stayed for four days and the second time I stayed six days. The second time, I stayed at laboring room for two days and was transferred to antenatal ward to observe uterine contractions and fetal heart sound. After that, I was transferred to laboring room again with the problem of pain from uterine contractions. I stayed for two days then I was transferred to antenatal ward again. I was boring to bed rest. At that time, I thought that if I could not get better. I would attempt to change the doctor or move to other hospital with the reason of why I could not get better. I didn't understand what happened to me. I asked the nurses why I could not get better. She could not explain me clearly and tell me asked the doctor when he visited." (ID.06-P9)

ID.07

A pregnant woman 30 years old with G_3P_1, 36 weeks of gestational age, said:
"My first daughter was premature baby. After birth, she had the lung problem and needed to monitor with the respirator for one week. At that time, I was suffering when I looked my daughter at incubator. I felt so sad and guilty. I prayed for my daughter everyday to get better soon. I hope that event would not occur again." (ID.07-P3)
"…her smiling face with friendly manner helped me to talk with her (the nurse). I dared to talk with her anything. She understood my problem and supported me. I trusted her. She never blamed me even sometimes I asked the same question in order to confirm. She treated me as a person." (ID.07-P6)

"I just separated with my husband for three months. I could not tolerate to live with him. I moved back to live with my mother. I had one daughter with four-year old. My daughter lived together with me. When I was hospitalized I concerned my daughter. She cried everyday to sleep with me. After I got better, I would like to come back home as soon as possible. I could not sleep at night I missed my daughter and worried about her... The doctor told me. I must take oral medicine for inhibiting my uterine contractions. I told him I want to take oral medicine at home with my family problem that sometimes the doctor and the nurses did not know." (ID.07-P8)
"…I assumed that my pain resulting from lifting heavy thing. So I would avoid lifting heavy thing that resulting in uterine contractions…The nurse advised the prevention of preterm labor and I asked my question and she explained me clearly. I believed in my own ability for maintaining my pregnancy."(ID.07-P13)

ID.08

A pregnant woman 17 years old with G_1P_0, 29 weeks of gestational age, said:
"In the earlier morning, I frequently urinated and felt a little bit abdominal pain. I could work at my office. Then, I found that the discharge from vagina looked like the mucous bloody show. I thought that it was abnormal of mucous bloody show because the gestation age just thirty weeks." (ID.08-P8)
"I stayed at laboring room for two days and then was transferred to antenatal ward. I was at antenatal ward for three days. At that time I was boring I needed to come back home with concerned my two-year old daughter. I told the nurse of my needs. She said that I should tell doctor when he visited. I did not dare to talk with the doctor. I thought that the nurse should help me to ask the doctor for me. I did not know why I stay at antenatal ward for a long time with bed rest. I could not go anywhere. The nurse said that if I would like go home I should bed rest. I didn't know the reason why I must bed rest more than other patients with the preterm labor as me. The first day in my patient's room had four patients. Next day three of them were discharged from hospitals they stayed at that ward only one night… I doubted why I stayed for three nights even I got well." (ID.08-P8)

ID.09

A pregnant woman 34 years old with G_1P_0, 30 weeks of gestational age, said:
"My mother lived together with me. When I had the problems of pregnancy I often asked her and she gave the good advice for me. She suggested me go to the hospital after I told her about my pain. She said that I might be the risk for preterm birth." (ID.09-P13)

ID.10

A pregnant woman 19 years old with G_1P_0, 32 weeks of gestational age, said:
"My aunt gave the premature baby and hospitalization about two months. At that time, I often visited her baby. When I saw her baby through incubator I felt so sad and very suffer. She and her family was suffering at that time and spent a lot of money for a high cost of medical treatment until now her daughter is not healthy... I worried this abnormal signs would be impact of my family. My family is quite poor do not have money to pay for the treatment expense…I expected that event (have preterm baby) would not occur in my family. I was praying everyday" (ID.10-P9)

ID.11

A pregnant woman 37 years old with G_2P_1, 35 weeks of gestational age, said:
"…this was the second time for admission with the same problem… uterine contractions and I got abdominal pain. In that moment I was not sure I could maintain pregnancy or not… I worried about my baby…was too small for survival. I knew that I might be risk for preterm birth." (ID.11-P10)
"I wanted seeing the nurse with the sense of humor. I thought that this atmosphere helped me to release the tension and I was comfortable to talk with her. I disliked seeing the nurse with the power when talking with the patient…such as "you must do that"…she looked the patient as the children…patient must follow her…" (ID.11-P8)
"Yesterday I could not sleep. I worried about my baby. I told the doctor and he told me about his plan that if he could not inhibit uterine contractions, he would terminate pregnancy because I had readmission two times. This time he thought that the baby was near term… If I decided to terminate pregnancy as the doctor suggested. I would like to ask the doctor again to make sure that my baby was healthy after birth. (ID.11-P10)
"…everything that I didn't understand I raised the questions to ask the nurses or the doctors when they visited me. They explained me clearly and I understood…" (ID.11-P10)
"Sometimes I also thought having this problem was quite a waste of time. I had to come to the hospital again and again. My husband was not rich and I needed to spend money for the transport too. I believed that sometimes the doctor and the nurse did not concern my psychological and social impact. They just cured me the physical problem. So I knew the best of my problem. " (ID.11-P9)
"Well…at the beginning, I have already known that I need to maintain pregnancy for the safety of my baby with taking the drug for inhibiting uterine contraction. As I already said, the doctor told me that the drug for inhibiting uterine contraction was important because of the first choice of drug even it has side effect. The nurse also told me the side effects of drug. So, it's like I have already known what is going to happen. (ID.11-P9)
"I was so good and with the knowledge that I have been received about my condition that has brought me into hospital." (ID.11-P10)

ID.12

A pregnant woman 29 years old with G_3P_1, 32 weeks of gestational age, said:
"For my opinion, during admission patient needed to take part in the decision-making by myself because it was the critical period or life-threatening situation. Patient must take part in the treatment that we would be received to make sure that it was right. That meant that it was reasonable treatment." (ID.12-P8)
"Since I got pregnancy I preferred to read the magazine related to maternal and child health. I knew about preterm labor from various sources such as reading the magazine, watching T.V. or listening to radio. I knew that how to talk with the doctor or the nurses and what information that I needed to know. I prepared my concerns or needs to consult them when they visited me. I concerned my baby with my experience of abortion. I would like to know my treatment regimens." (ID.12-P16)
"When the nurses used the term of "you" or "your", it looked like having the gap with the patient. If changed to the term "we" or "our", I thought that it would be decrease the gap between the nurses and the patients. I also believed that some nurses didn't pay attention of this term." (ID.12-P10)
"I was afraid of the injection needle. It was extremely fearful because I had never received intravenous fluid before…I did not want any more pain. It was the terrible pain that I had. I told the doctor to take oral medication instead of intravenous drug. He said 'we would try if it could not inhibit we needed to change to intravenous drug later."(ID.12-P8)
"I knew the treatment regimen. I would like try to talk with the doctor. Could I take oral medicine instead of taking the subcutaneous drug after receiving the intravenous drug?" (ID.12-P9)
"I was afraid that after birth the baby might have respiratory disease because of lung immaturity. It needed long term treatment. I decided to maintain pregnancy as the doctor suggested. (Pregnant woman ID.12-P4)

ID.13

A pregnant woman 18 years old with G_1P_0, 31 weeks of gestational age, said:
"After transferring to the antenatal ward I have uterine contraction again and needed to transfer back to labor room again to receive drug for inhibiting uterine contractions. I was afraid of that…" (ID.13-P10)
"I always felt inferior when I was with the doctor or the nurses I didn't dare to tell them about my needs.. I should follow the doctor's or the nurses' advice. I believed that if I against them, I was afraid that I would not receive a good care from them" (ID.13-P10)
"Pain is as trigger to tell me that I should pay more attention of my pregnancy. I worked so hard sometimes I forgot I am pregnant woman. I was lifting heavy thing. This must be my karma that this happened to me. " (ID.13-P09)

ID.14

A pregnant woman 25 years old with G_1P_0, 36 weeks of gestational age, said:
"…My condition was quite different from the previous pregnancy. I got pain and I knew there was something wrong in my body but I don't understand what I'm exactly sick with worried my baby would be impacted." (ID.14-P3)
"I had not the experience of pregnancy. This is the first time for me with having abdominal pain. I got pain as uterine contractions when we have the menstrual period. It was quite painful and I could not tolerate. At that moment, I thought that it was not safety for my baby." (ID.14-P10)
"…I had signed the informed consent after I admitted. It meant that I could say "no", if I did not need that ultrasound because I had examined by the ultrasound on the last Monday or three days ago. I thought it was not different and it was necessary to ultrasound again. I had pay a lot of money for the last hospitalization with the same problem (preterm labor)…"(ID. 14-P13)
"I had the courage to talk with nurse. She is friendly manner. But she looked like busy. So I was afraid that she did not answer me if I asked her." (ID.14-P10)

ID.15

A pregnant woman 36 years old with G_4P_3, 32 weeks of gestational age, said:
"At that time I felt abdominal pain. I thought about the last pregnancy with preterm birth, my mother and my husband made sacrifices to visit me everyday. Sometimes my husband would leave work to visit me. I felt that my mother and my husband were tired. My home was far from here and they needed to wait for the bus for quiet a long time." (ID.15-P12)
"I worked so hard, six days per week with three children …two daughters and one son. So, I did not have the time to access information regarding preterm labor. At that time, I wasn't ready to involve in making-decision of the treatment…I had no idea about this information. I thought that the doctors and the nurses should provide information for me. I could know about the preterm labor from them. (ID.15-P13)
"This was the second time to admit here. I was quite familiar with the nurses. They are very nice, friendly… pay attention for nursing care the patients. When I had any problem I could talk with the nurse. (ID.15-P9)
"…two days later, I felt better and the doctor plan to discharge me tomorrow. I asked the drug from the nurse. She explained me and told me about how to prevent uterine contractions again that leading to preterm birth and gave me the leaflet regarding prevention of preterm birth. I assumed that I carried heavy things like taking my daughter and lifting heavy thing resulted in my pain. So I would avoid carrying heavy things and bed rest more…"(ID.15-P16)

ID.16

A pregnant woman 33 years old with G_1P_0, 29 weeks of gestational age, said:
"I quiet familiar with the physician and the nurses in the laboring room. So I easily consult or ask the question or request my needs or my concerns with them even though this is the first time of pregnancy." (ID.16-P14)
I always questioned if a test was necessary and why it was being done.
The first day of admission I had a lot of treatment such as blood test, urine test, ultrasound, fetal monitoring, intravenous drug, and injection the drug for baby's lung maturity. I asked everything that the nurses provided for me. I believed that the treatment invasive not only my life but also my baby's life. (ID.16-P8)

ID.17

A pregnant woman 17 years old with G_1P_0, 33 weeks of gestational age, said:
"At that time, I needed anyway to relieve my pain. It was very painful. I had no idea to talk with anybody… Not already to talk anything… Just said the words 'very painful' I suffered terrible pain from my uterine contractions …I followed everything that the nurses' advice… This was the first time pregnancy and I had no experience of preterm labor. I unexpected this event would occur with me...At that time…it meant that during admission…I confused to cope with my problems. I only focused on my pain. I felt that I could not control my emotional expression. I thought that crying is one way for me to relieve my tension."(ID.17-P8)
"I lived with only my spouse. If I had preterm baby my spouse and I would be trouble. Nobody helped me to rear baby…Moreover, after giving birth; I would go back to study." (ID.17-P14)
"I did not know anything about preterm labor. I just know I got pain. For me, it was impossible to take part in clinical decision-making. At that moment I frightened the unfamiliar health personnel and the atmosphere where I looked at other pregnant women was crying resulting from their pain and the nurses was very busy…So I took the responsibility on the hand of doctors and nurses. That way was safety for my baby's life." (ID.17-P15)
"I thought that how I talked with physician…I lacked information about preterm labor. After the nurse told me that I needed to admit for receiving the drug in order to relieve uterine contraction…(ID.17-P8)
"I was shyness to talk with the doctor. I was afraid that he would blame me. So, I just waited for hearing from him."(ID.17-P8)
"It was boring to bed rest. The abdominal pain had diminished. I wanted to go back home. I waited for the doctor to visit, and asked the nurse when I could go back home. She said that I should ask the doctor and she thought that the doctor might discharge me today. (ID.17-P12)

ID.18

A pregnant woman 23 years old with G_1P_0, 32 weeks of gestational age, said:
"At that time, I was so hard for me to make relationship with the doctor or the nurse. Because I got pain at the same time I faced with unfamiliar health personnel and the quite terrible situation…I heard a pregnant woman was crying from pain…I quite confusion. It was complicated situation for me to understand what the doctor or the nurse said. They used the technical term that I didn't understand. It was difficulty for me." (ID.18-P12)

ID.19

A pregnant woman 19 years old with G_1P_0, 29 weeks of gestational age, said:
"I was fearful…how about my baby? I was afraid that the baby would be abnormal. It made me anxious." (ID19-P6)
"The first day…I was frightened when I arrived at labor room because this is the first time of my hospitalization. I saw many pregnant women with some pregnant women was crying …I thought that she was giving birth…she was painful resulting from uterine contractions…I saw around the ward all most pregnant women was receiving the intravenous fluid. I quite feared… I often tried to talk with the nurses and ask about my baby's condition. They tried to talk with me even though they were busy. The nurses were friendly manner. My first impression was good for them that made me easily to talk with them." (ID.19-P9)
"During I hospitalized, I had received information about preterm labor from the doctor and the nurses every time when they visited me. They explained quite clearly the treatment regimens or the nursing procedure. The nurse advised how to prevention my preterm labor. I was able to see a picture that I should do for my baby. The was the good for me to have a chance to learn my problems" (ID.19-p14)

ID.20

A pregnant woman 32 years old with G_2P_1, 31 weeks of gestational age, said:
"This situation was as the significant period. It meant that if I made a false decision I would feel guilty or have the conflict. So I should make a decision. At that time I thought that I chose the best for my baby. My baby's survival was the first option that I concerned… I should know that how the doctor or the nurse treated me. At that moment I got confusion. I didn't know when my pain diminished. It was uncertainty." (ID.20-P13)
"The best way that helped me to understand my symptom and my treatment was asking the doctor or the nurse. I could know how I could do. For example, the nurse told me I needed to bed rest. Yesterday, I got better. I asked her could I walk to toilet. " (ID.20-P.13)
"I anticipated that I would be able to continue my pregnancy. Preterm labor would not be recurrence. I believed that I could overcome my problems. Certainly, I extremely expected that I must have a healthy full-term baby." (ID.20-P14)

"I doubted that why the doctor didn't terminate my pregnancy because it near term as the last pregnancy I gave birth as about this gestational age at provincial hospital. My first baby was healthy. I didn't dare to ask the doctor. I afraid that he would be not so good sense as not trust him. It was impossible to say that with him, it was not appropriate manner. I assumed that it was a hospital policy treatment of every pregnant woman with pain before the expected date of confinement."(ID.20.-P12)

ID.21

A pregnant woman 17 years old with G_1P_0, 36 weeks of gestational age, said:
"I don't ask. To think about it, I won't know much anyway. So, I don't ask I just take the treatment." (ID.21-P10)
"I thought that if I made a good relationship with the doctor or the nurse at that time, I would dare to talk my needs or my concerns or share my feeling with them. They didn't prefer the difficulty patient…it meant that they preferred the patient who was easy to approach or follow them." (ID21-P10)
"The doctor and the nurses visited me every day with the hurried manner. I would like to ask them some questions but I change my mind. Sometimes I thought to open my mouth to talk but they walk away. I understood they were very busy with a lot of patients waiting for them." (ID.21-P12)
"As far as I'm concerned hospital is a place where I don't really ask questions. I seem to expect to be told. Information was thought to be too technical, difficult to understand; all of which inhibited my asking for information."(ID.21-P15)
"I slept on the bed for three days. I felt constipation. The nurse provided the bed pan for me. I told her I want to go to the toilet was better because it was so hard for me to sit on the bed pan. Then, she helped me to the toilet. She told me that constipation is the leading to uterine contractions. (ID.21-P7)
"I was afraid to say what I concerned or I needed. I was carefully said anything that making the doctor or the nurse felt not so good (*greng-jai mhor*)… They were knowledgeable persons and I trusted their capability to treat and care me. I hoped that they provided the best care for me. I should comply with the doctor and the nurse's suggestions. This was the best ways for me." (ID.21-P10)
"Pain is my karma that I can't leave it, I must pay back for my karma (by more concerning for baby)….It was my karma that I had to suffer with pain. So I was reluctant to share my feeling or my troubles with the nurse. It depended upon the doctor or nurse told me I would comply with them." (ID.21-P.12)
"I did not agree with the physician for admission me a long time just taking oral medicine to relieve the pain and bed rest. I thought that I could go back home to take oral medicine and bed rest at home was better…I was boring to bed rest. I did not know what reason the physician did not discharge me. The nurse told me my fetal heart sound was OK…When I told the physician…I want to go home. He just said …wait for…wait for…." (ID.21-P.12)

ID.22

A pregnant woman 30 years old with G_2P_0, 30 weeks of gestational age, said:
"I had the experience of abortion. Now I had no children. This baby was my hope. I worried about my baby. When I got pain as the uterine contractions I imagined the day that I had loss my first baby. I felt very sad and I was crying all that day….." (ID. 22-P15)
"First day of admission, I went to labor room. I imagined the picture "the day that I had the experience of abortion"…my spouse and my mother felt so sad because of the first baby of my family. They were very disappointment for bad event. In addition, I had the infertile problem or difficulty to get pregnancy…I pay much money to get pregnancy. If I gave preterm baby I would be pay more money than term baby." (ID.22-P14)
"After telling my symptoms, the doctor told me I had preterm labor. At that moment, I was quite frightened. He explained the planning of treatment. He suggested me admitting to receive drug for inhibiting uterine contractions was necessary. I agreed with him… The nurse told me about pregnant women on the next bed with the same symptom as me, now she got better after receiving drug and was transferring to the antenatal ward to continue observation." (ID.22-P15)
"When the doctor visited me, they often asked me "how are you?" I told him about my needs. He explained the planning for discharge me and change to oral drug. I asked him to ensure that I could go back home tomorrow." (ID. 22-P14)
"I was able to know that how the doctor and the nurse manage the risk of preterm birth. They explained for me quite every step that they treat me. It was so good for me to understand in order to prevent the preterm labor." (ID.22-P9)

ID.23

A pregnant woman 34 years old with G_4P_2, 32 weeks of gestational age, said:
"Now I had two children with five and two years old. If I would be having a preterm baby, it was so difficulty for my family. My mother was sick with hypertension. My father was passing away last two years. My family had four persons live together… my mother, my spouse, and my two daughters. My spouse was going to work six days per weeks at …." (ID.23-P7).
"I told my spouse about the symptom…I got pain and the baby movement was not so good… because he was a father of my baby and it was his responsibility to know about our baby's condition or it was his duty to care for unborn baby as the reason for telling my spouse. We had two children together." (ID.23-P12)
"…The time was important for me. For example, if the nurses could not provide the time for patients, they would not know the real patient's problems. They treated only the physical symptom, but they could not treat the patients as a whole person." (ID.23-P13)

“For my thought, I would like the nurses to ask patient ‘what’ ‘how’ or ‘why” more than ‘yes’ or ‘no’. It meant that the nurse used the open question instead of ‘close question’. They could listen to my story that might be involved in my symptom. Sometime I misunderstood the doctor and the nurse talked about my symptom by using technical terms I didn’t understand. It was necessary to ask them again to make sure that I understood.” (ID.23-P16)
“I didn’t like the doctor or the nurse talk with me with the power such as you must on bed rest. You must follow the doctor’s suggestions. It felt like my activity was in control of the doctor or the nurse. I didn’t have the freedom. I preferred to the doctors or the nurses talk with the patient with the sense of “we should do that…or how we do that…it meant that we were take responsibility together.” (ID.23-P14)
“I was praying every night for my healthy baby. I was looking forward to seeing my baby. I believed that my baby would be full term baby. My spouse frequently said with my unborn baby when he visited me. He touched my unborn baby and said: ‘be healthy baby… father was praying for you and waiting for seeing healthy baby …I attempted to do the best for my baby in order to prevent preterm labor.” (ID.23-P12)
“…I asked about my baby’s condition. The nurse said, it was OK…I wanted to know the numbers. She said “you didn’t need to know that…I felt upset…why I could not know…what the reason.” (ID.23-P9)

ID.24

A pregnant woman 32 years old with G_3P_2, 31 weeks of gestational age, said:
“The baby is as my family’s gift. Every body is waiting for the full term baby will be born. I knew that if I gave preterm baby my spouse and my mother would be suffering as me. I needed to maintain pregnancy. At that time I hope that I could maintain my pregnancy. So I needed to know what was the planning of treatment that I would be received for relieving my pain.” (ID.24-P16)
“The nurse set the fetal monitoring for me in order to detect the baby heart rate. I got the difficulty to sleep because of uncomfortable from the belt of fetal monitoring. I told this problem to her.” (ID.24-P10)

ID.25

A pregnant woman 23 years old with G_1P_0, 34 weeks of gestational age, said:
“This is the first time of my pregnancy. I quite worried my pregnancy and my baby. Last Monday… once I felt abdominal pain I called my spouse and told him about my pain. He suggested me go to hospital for safety of our baby.” (ID.25-P9)
“I would like the doctor and the nurse told me about what I should do after I told them about my pain or my concerns. I wanted to know the planning of treatment. If I talked with nurse or doctor I could know what happened to me.” (ID.25-P9)
“I had stayed at hospital four days. The doctor and the nurses were very nice with friendly manner. They listened to my problems and explained for me quite clearly even though they were busy. I appreciated them.”(ID.25-P12)

"I thought that participation in decision-making was so good even this time I could not have the chance to take part in decision-making. I took my responsibility on the hand of the doctors and the nurses. At this time I got the experience of preterm labor and hospitalized experience. I believed that it's not hard for me to involve in decision-making. I had a chance to learn how to involve in decision-making. Nurses always asked my opinion and encouraged me to make a decision. I embarrassed to say anything. Now, I thought that I should take responsibility to make decision by myself. This was my life and responsibility of mother to protect the unborn baby's life. I should involve in decision-making next time." (ID.25-P14)

ID.26

A pregnant woman 19 years old with G_1P_0, 32 weeks of gestational age, said:
"When I saw pictures of other babies' deformity from the television or anywhere, I feared that my baby would be like that." (ID.26-P3)
"I saw the physicians and the nurses were very busy. The doctor told me about the treatment regimens. Then, the nurse took the drug for relieving uterine contractions to me and took the blood test before giving the drug via intravenous fluid. The nurse explained the drug for me and I would like to ask about the blood test. She looked like busy. Then, I postponed asking her later." (ID.26-P12)

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