Addressing the patient's agenda in the reorganization of antenatal and infant health care: experience in one general practice

JOHN MELLOR

NAOMI CHAMBERS

SUMMARY

Background. *Antenatal care is outdated and largely unevaluated. The study practice is committed to involving patients in their own health care. It was decided to use the views of patients to guide a review of antenatal and infant health services.*

Aim. *The study, carried out in 1993, was designed to find out what patients' priorities were, and what they thought were the strengths and weaknesses in the organization and delivery of antenatal and infant health care.*

Method. *A total of 52 women attending antenatal appointments were interviewed at the practice using an interview topic guide within a qualitative research framework. Fourteen parents attending a day centre with their under five-year-olds participated in two focus groups. The findings of the interviews and focus group discussions were compared.*

Results. *The interviews revealed a high level of satisfaction with midwife care, although some changes in the organization of antenatal bookings and classes were indicated. Parents expected to be seen swiftly at home or at the surgery when their infant was ill, and these high expectations were not always met. There was some degree of confusion and frustration over the role of the health visitor. The views expressed in the focus groups were broadly similar to those expressed in the interviews.*

Conclusion. *The findings suggested that there was considerable potential for developing the role of both the midwife and the health visitor, and integrating their work more closely in the primary health care team. Examples are given of how these findings have altered the organization and delivery of antenatal and infant health care in the practice. The study showed that finding out and acting upon the views of patients is a practical way forward in the reshaping of services.*

Keywords: antenatal care; health services for children; health service delivery; patient satisfaction, patient expectations.

Introduction

RECENT years have seen a move towards increasing patients' involvement in their own care, and the practice in which the present study was undertaken is committed to involving patients in their own health care. This includes encouraging patients to become more aware of factors affecting their health. The practice has been committed to developing the concept of the 'one-stop health shop' based in the primary care centre. Two areas of health care which are important in this regard are antenatal care and infant health care, which have been organized in this practice along traditional lines.

The current organization of antenatal care in the United Kingdom is outdated and largely unevaluated. Hall and others have challenged the value of the usual schedule of visits and tests.[1-3] The predictive value of maternal weight gain for outcome of pregnancy is low,[4,5] testing urine for glucose is not an effective screening method for gestational diabetes,[6] and listening routinely to the fetal heart has shown no value other than reassurance for the mother.[7] Why do health professionals persist in such rituals?

Although the research study was carried out before the publication of *Changing childbirth*,[8] the three principles of acknowledging the woman as the focus of care, of developing services accessible to all, and of involving women in the monitoring and reorganizing of services, were implicit in the vision of the practice. It was known that others, for example Marsh,[9] Stewart[10] and Haworth,[11] had had similar ideas and had encouraged women to take charge of their own health, and had increased the input of psychological care into a more streamlined system of visits. However, it was not known how the practice's patients would feel about a change in health professionals' roles, what their views on the present care offered were, and which interventions they valued. Hall and colleagues found that many women in their study felt that the interval between traditional antenatal visits was too long, and that there was an unmet need for advice and reassurance.[1]

It was decided to conduct a review of antenatal care and infant health care and to involve patients in the process. Research using a qualitative approach was therefore commissioned. Patients views were sought on current antenatal and infant health care services, what they appreciated, and what they thought could be improved. It was hoped that the clients' opinions would guide the practice in changing these services.

Method

The study practice, which has a list size of 15 600 patients, is based in a health centre. The population served is mainly from social classes 3–5. The primary health care team comprises five men general practitioners, one woman general practitioner, two midwives attached to the practice, four health visitors attached to the practice and four practice nurses. It is a second-wave fundholding practice. Pregnant women are assigned to a named midwife for the antenatal care.

An external researcher (N C) with experience in qualitative health services research was funded by Northamptonshire Family Health Services Authority to plan the work and to carry out the research interviews. N C and J M agreed that indepth interviews with individual women patients would be the most appropriate method for gaining insight into areas of service delivery which the practice patients felt needed attention. A topic guide for the interview was developed by the primary health care team. This guide allowed consistency of coverage of topics across all the interviews, but also enabled women to expand on subjects of par-

J Mellor, MA, MRCP, MRCGP, general practitioner, Corby. N Chambers, BA, DipHSM, MHSM, researcher, Ashbourne.

Submitted: 18 August 1994; accepted: 16 January 1995.

ticular concern. Such an approach is based on reflexive qualitative research as advocated by Hammersley and Atkinson,[12] allowing clients' concerns to emerge, but also reflecting the priorities of the professional team.

After a pilot study comprising nine interviews, the women were recruited to the study by the midwives at the time of their antenatal visit. Women were interviewed by N C, who was not known to them. The interview topic guide covered questions and prompts about the following issues: access to the health centre and access in the health centre; appointment systems and waiting times for clinics and surgeries; the nature of midwife, health visitor and doctor consultations; the main events during pregnancy and during the neonatal and child health surveillance period; the quality of advice and information provided; what women thought was most important about the services provided; what women thought was done particularly well; and areas for improvement. Interviews lasted approximately 25 minutes. As the interview developed, the women chose the topics about which they had most to discuss and also raised other topics.

In order to compare findings, two focus groups were conducted by N C at a day centre elsewhere in the town for under five-year-olds and their families. Recruitment to the study was from two pre-existing parent groups. A simplified version of the same topic guide was used in the group discussions.

Analysis of the results was carried out by N C. Key themes that emerged from the data were identified and grouped, using Glaser and Strauss' grounded theory approach.[13] The focus for the analysis, in line with qualitative methodology, was the range and depth of concerns expressed, rather than the proportion of participants expressing particular views.

Results

A total of 52 women were interviewed at the practice over a five-week period in January and February 1993; five other women had been invited to take part in the study but had refused. Of the 14 people interviewed in the focus groups in March 1993, three were fathers. The social class characteristics of the participants in the interviews and the focus groups matched the practice population. Most of the participants were aged between 20 and 29 years; there were four teenagers (aged between 16 and 19 years). Of the 52 women interviewed at the practice, 12 were pregnant for the first time, and the remainder had one or more children.

The results are presented as a chronological account of antenatal care and care of an infant.

Antenatal care

The women reported no difficulties with access to or in the health centre. During the course of the study, in place of a block-booking arrangement for appointments, the midwives started an individualized appointment system which the women reported they much preferred.

Most women reported that their antenatal care was given in equal amounts by the general practitioner and the midwife. Apart from one exception the women interviewed were happy to be cared for by their midwife, as long as they could see the doctor for a check up if they wished. They saw their midwives as specialists in their field, many being mothers themselves, who gave a personal service and who were easy to talk to. Two of the pregnant teenagers were more circumspect, reporting that they had not confided their fears (mainly about the birth itself) to their midwife.

Most women liked the home visit that the practice midwives made at between 10 and 12 weeks when making the detailed arrangements for the birth in hospital. It was considered to be a valuable opportunity to get to know the midwife in relaxed surroundings. However, four women had not been happy with the visit: they could not see the value of the visit, they felt that they were being checked on, and one said it was embarrassing because she was living with parents-in-law.

Many women were pleased with the content and style of the antenatal classes, especially the parentcraft class for couples, which was oversubscribed. Some interviewees, including the teenagers, said that they did not see the purpose of going. A few women mentioned that the antenatal classes concentrated on straightforward births, and not on different scenarios or complications.

The women reported that the minor problems of pregnancy had been dealt with sympathetically by both the midwife and the general practitioner. A number of women had suffered a miscarriage; follow up by the midwife had been much appreciated but some women were critical of the way in which their doctor had dealt with the situation. Two women had had infants who had died soon after birth. Again, these women felt that the midwife had provided more sympathetic care than their doctor, for example by talking from time to time about the infant who had died.

The participants in the two focus groups revealed similar preoccupations with the importance of individualized care in pregnancy, and the need for antenatal classes to cover variations from the straightforward delivery scenario. The three men who participated in the focus groups said that they had often felt marginalized by health service personnel during their partner's pregnancy, particularly when something was going wrong.

Care of an infant

Women expected to be seen swiftly by the doctor when their infant was ill. Many women felt strongly that the receptionists were good at trying to fit them in with an appointment and others felt, conversely, that receptionists were unhelpful. Some women were critical that they were expected to bring ill infants to the surgery when they had requested a home visit.

Women from large families reported that they had less need of advice and help. Some women said that they felt quite lost with their newborn infant, especially their first infant. Many mothers felt that their health visitor had been helpful, but six women made negative comments. They did not really understand what the health visitor did and reported that advice was unhelpful or inconsistent. For women without a telephone, contacting the health visitor was a problem, and women did not feel that they were encouraged to leave messages.

Findings from the focus groups on the subject of care of the infant were similar, although there was more discussion about the doctor's role, and a sense that advice and treatment for the same symptoms could vary between doctors. Participants welcomed doctor consultations where the parents' views were sought, where a mother's intuition was given some weight. Fathers, however, sometimes felt that they left the surgery without enough information.

Discussion

The findings from the two focus groups corresponded closely with the main issues that arose from the individual interviews in the practice. This meant that, within the qualitative research framework, the findings had a degree of validity and relevance[12] which highlighted the areas of service delivery needing attention.

Women were happy to be cared for by the midwife, and there was little indication of any potential resistance to developing the midwife's role. However, women felt it was necessary to maintain access to the doctor. With this in mind, the midwives in the practice have started conducting antenatal clinics at a time when

the doctor is available if needed. Following discussion with an obstetrician at the local hospital, the schedule of antenatal visits involving the general practitioner or hospital has been revised. A normal multipara is seen by the general practitioner at 12 weeks and at 36 weeks only. A primigravida is seen by the general practitioner at 12 weeks, 26 weeks and 38 weeks, and by the consultant at 14 weeks, 34 weeks and 41 weeks. For a woman who is having problems with her pregnancy, an individualized schedule of care is organized. Midwives see the women at all other scheduled visits.

Although many women liked the antenatal home visit by the midwife, some were uncomfortable with this, particularly if there were difficult social circumstances. The midwives have therefore started offering women the choice of a home visit or a clinic visit.

The antenatal and parentcraft classes were valued, and there appeared to be an unmet need both in terms of places available on the courses and the type of issues discussed. In view of the reluctance expressed by some women to attend classes it was considered that this type of care should be more fully integrated into routine antenatal clinic visits. The practice therefore decided that there should be a shift in emphasis from routine clinical measurements to more antenatal care of this kind. To that end, the help of a practice nurse has been enlisted who has experience of working in sexual health education, and family planning with teenagers. The routine antenatal clinic visits have been converted into small group sessions involving women at a similar stage of pregnancy and of a similar age. This has encouraged social contact and has allowed educational input and the development of parenting skills without the need for additional antenatal clinic visits.

Comments from the interviews showed that women who had had a miscarriage or stillbirth needed careful follow up. As a first step, the midwife now tries to visit the women within the first 24 hours of the event. The doctors are planning to address their role and skills in dealing with these situations.

Parents expected to have swift access to the doctor when their infant was ill. They were reluctant to bring ill infants to the surgery. The practice decided to address these problems in three ways. It was decided that education would be provided during the antenatal period, for example providing reassurance about when to call the doctor and when to bring the sick infant to the surgery to be seen. This was considered preferable to discussing these things when the infant was ill, at which point parental anxiety and concerns make education difficult. It was decided that there should be further training of reception staff about the need to respond sympathetically and quickly to the concerns of new parents. It was also decided that there should be improved patient access to health visitors, to provide support and help as an alternative first point of contact.

There appeared to be a problem with access to health visitors at certain times. In order to tackle this, a policy has been introduced that ensures that at least one health visitor is available by telephone throughout the day on weekdays; a message book has also been introduced. The practice aims to increase the health visitor's role in the team and the health visitors are to start their own surgeries with their own consulting room. In conjunction with their managers, health visitors are being encouraged to look at their skills and the range of conditions which they would like to manage. Use of these surgeries will be facilitated through women's increased contact and involvement with health visitors during the antenatal period. To ensure consistency of advice, general advice protocols have been developed jointly by general practitioners, health visitors and practice nurses for various minor problems, such as infant feeding difficulties.

The research project showed that the process of obtaining patients' views on services could be a powerful tool in the successful management of change. The views added motivation to the health professionals' sense that their services needed updating. The practice's philosophy was to develop a 'one-stop health shop' and to empower patients to look after their own health. The primary health care team wanted to improve antenatal and infant health care in response to these ideals and to integrate patients' views in this strategy for change. The research allowed the practice to do this and, at the same time, to assess the value of a qualitative approach to research. In order to evaluate this fully, patients' and health care professionals' views on the changes that have been made will be explored in a future study.

References

1. Hall M, Ching P, MacGilvray I. Is routine care worthwhile? *Lancet* 1980; **2:** 78-80.
2. Hall M, MacIntyre S, Porter M. *Antenatal care assessed. A case study of an innovation in Aberdeen.* Aberdeen: Aberdeen University Press, 1985.
3. Steer P. Rituals in antenatal care — do we need them? *BMJ* 1993; **311:** 697-698.
4. van de Spuy Z, Steer P, McCusker M, *et al.* Outcome of pregnancy in underweight women after spontaneous and induced ovulation. *BMJ* 1988; **296:** 962-965.
5. Parker JD, Abrams B. Prenatal weight gain advice, and examination of the recent prenatal weight gain recommendations of the Institute of Medicine. *Br J Obstet Gynaecol* 1992; **99:** 664-669.
6. Gillmer MDG, Oakley NW, Beard RW, *et al.* Screening for diabetes during pregnancy. *Br J Obstet Gynaecol* 1980; **87:** 377-382.
7. Sharif K, Whittle M. Routine antenatal foetal heart rate auscultation: is it necessary? *J Dis Gynaecol* 1993; **13:** 111-113.
8. Department of Health. *Changing childbirth.* London: HMSO, 1993.
9. Marsh G. New style obstetric care. In: *Modern obstetrics in general practice.* Oxford University Press, 1985.
10. Stewart N. Holistic pregnancy care in practice. *Aims Q J* 1988; **2:** 3.
11. Haworth RN. Antenatal care project [letter]. *Br J Gen Pract* 1994; **44:** 140-141.
12. Hammersley M, Atkinson P. *Ethnography: principles in practice.* London: Routledge, 1983.
13. Glaser B, Strauss A. *The discovery of grounded theory.* London: Weidenfeld and Nicholson, 1967.

Acknowledgements

We would like to acknowledge the help received from all the women who took part in the study, the other members of the primary health care team for their involvement, and Northamptonshire Family Health Services Authority for financial assistance.

Address for correspondence

Miss N Chambers, Stanshope Hall, Stanshope, Ashbourne, Derbyshire DE6 2AD.