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A Qualitative Study of Women's Experiences of Communication in Antenatal Care: Identifying Areas for Action

Rosalind Raine, Martin Cartwright, Yana Richens, Zuhura Mahamed, Debbie Smith

Abstract To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users. Focus groups and semi-structured interviews were used to explore communication experiences of thirty pregnant women from diverse social and ethnic backgrounds affiliated to a large London hospital. Data were analysed using thematic analysis. Women reported a wide diversity of experiences. From the users' perspective, constructive communication on the part of health care providers was characterised by an empathic conversational style, openness to questions, allowing sufficient time to talk through any concerns, and pro-active contact by providers (e.g. text message appointment reminders). These features created reassurance, facilitated information exchange, improved appointment attendance and fostered tolerance in stressful situations. Salient features of poor communication were a lack of information provision, especially about the overall arrangement and the purpose of antenatal care, insufficient discussion about possible problems with the pregnancy and discourteous styles of interaction. Poor communication led some women to become assertive to address their needs; others became reluctant to actively engage with providers. General Practitioners need to be better integrated into antenatal care, more information should be provided about the pattern and purpose of the care women receive during pregnancy, and new technologies should be used to facilitate interactions between women and their healthcare providers. Providers require communications training to encourage empathic interactions that promote constructive provider–user relationships and encourage women to engage effectively and access the care they need.

Keywords Communication . Antenatal care . Qualitative methods . Thematic analysis

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Introduction

The importance of good communication in antenatal (prenatal) care (ANC) is well recognised. This is in part in recognition of the effect that good communication can have on patient outcomes including anxiety, pain control, functional and physiological status, satisfaction and the understanding of information [1–4]. It also reflects the need to shift towards a partnership model of care in an increasingly consumerist society in which there is greater access to information and where effective communication has repeatedly been prioritised by women [5–7].

United Kingdom (UK) government policy and the General Medical Council [8] of the UK emphasise the need to communicate sensitively and to provide appropriate and accessible information to pregnant women [9] to facilitate

informed choice [6, 10]. In addition, the English Royal Colleges have published standards for high quality communication in ANC [11]. These recognise that effective communication encompasses a variety of components including the disclosure of medical and social information, the development of empathy in the patient–provider relationship, participation in shared decision making and assurance of satisfaction with the outcomes of the encounter [12]. Yet the Healthcare Commission's recent review of maternity services in England identified problems with communication [13]. Some women reported that they had not always been spoken to in a way they could understand, treated with kindness, given the information they needed or involved enough in decisions about their care [13]. These results correspond with other research which found that pregnant women want their providers to help them to relax and to feel in control [14]. These findings raise questions about the specific features of communication that address women's concerns and that may, in turn facilitate the patient outcomes described.

To achieve insight into the elements of communication that need to be tackled, four key areas need to be explored. These are: the identification of points in the care pathway where communication problems arise; the characteristics of communication that are highly valued by women; the specific components of communication that need to be addressed; and how women respond to effective and to poor communication. The aim of our research was to address these issues within the English National Health Service (NHS). All NHS care is free at the point of access. Women are encouraged to make contact with an NHS professional as soon as they learn they are pregnant. Usually this entails visiting their primary care provider (their general practitioner [GP]) who will then refer them to their local midwifery service. However women can access their midwives directly.

Methods

This study was conducted in line with prevailing ethical guidelines to protect the rights and welfare of all participants. The research was approved by the relevant Committee on the Ethics of Human Research.

Recruitment

The research was conducted between April and August 2008 at one NHS Trust (i.e. hospital) in central London, England. There are 33 NHS maternity services across London and this research was undertaken in one of the largest, delivering 3,700 babies annually serving a socially and ethnically diverse community. The two largest non-White minority ethnic populations in the hospital's catchment area are Somali and Bengali [15]. In an attempt to ensure that we would obtain a sample that was representative of the population, we recruited from several antenatal settings. In the NHS, antenatal services are provided in both primary care settings (i.e. by GPs and midwives working in local health centres) and in secondary care setting (i.e. hospitals). To maximise the heterogeneity of our sample we recruited participants in the hospital, eight community antenatal clinics situated in socially and ethnically diverse areas and via a community parenting group for Somali women and a Bengali Women's Health Project. Within the hospital, participants were recruited from the antenatal waiting room (which services low and high risk women), the ultrasound clinic and the glucose tolerance testing clinic.

Pregnant women were eligible for inclusion if they were capable of understanding the nature of the study and of providing consent. The purpose of the study was explained in English, standard Bengali, Sylheti (a dialect of Bengali) or Somali as appropriate. Participation was incentivised with the offer of a £20 retail voucher. Consenting women were asked whether they would prefer to take part in a one-to-one interview, to be arranged at a time and place of their choice, or join a 'small group discussion' with other pregnant women at a mutually convenient time. Focus groups can stimulate self-interpretation by participants through the sharing of viewpoints and can therefore add depth and context to the discussion [16]. However they tend to suffer from high drop-out rates. Individual interviews can be arranged in a more flexible manner and often allow a clear, detailed narrative to develop. Data collection methods were therefore combined to maximise participation amongst hard-to-reach groups.

Data Collection

All participants provided demographic data including their level of educational attainment. They also categorised themselves in terms of ethnicity using a coding system based on the 2001 Census [17] and indicated the language that they preferred to speak in. Non-English-speaking focus groups and interviews were conducted in standard Bengali, Sylheti or Somali.

Focus Groups Focus groups function effectively when they comprise participants who are homogeneous with respect to salient features of identity [18, 19]. Participants were therefore assigned to a focus group on the basis of their self-reported ethnicity, their preferred language and, for White women only, their relative social advantage. Their level of educational achievement was used as an indicator and women with qualifications above GCSE were defined as socially advantaged. Thus, five focus

groups (FG) were established: English-speaking Bengali (ESB), non-English-speaking Bengali (NESB), non-Englishspeaking Somali (NESS), high educated White British (HEWB) and low educated White British (LEWB). Focus groups lasted approximately 80 min and were conducted in hospital and university meeting rooms. Travel expenses and taxis were offered to participants. The focus groups were moderated by the female members of the research team in English, Somali and Bengali.

Interviews Semi structured interviews lasted approximately 20 min and were conducted at various locations to suit the needs of individual participants, including their homes. Non-English interviews were conducted in Somali or were interpreted into Sylheti.

To maximise consistency, we used a standardised topic guide (Table 1) which covered the research questions described above and all researchers attended a training session on the use of the guide and listened to a recording of one of the members of the research team (DS) conducting an interview before conducting interviews themselves.

Analysis

We conducted a thematic analysis to identify themes from a realist perspective. Thematic analysis is a widely used qualitative analytic method for identifying, analysing and reporting patterns (themes) within data [20]. By taking a Realist viewpoint, we reject the dichotomy between positivism and relativism, and instead maintain that there are facts about the world that can be studied and assessed. A realist acknowledges that the nature of a 'fact' is shaped by both researcher and respondent. Our role as researchers is not so much to uncover 'facts' or 'truths' but to represent them accurately [21].

Table 1 Summary of topic guide

Suspecting you were pregnant & initial contact with Health Care professional When (in weeks) did you suspect/find out you were pregnant? Did you tell a Health Care Professional? What was it like making an appointment with your GP (or other HCP)?

Was this first meeting with your GP (or other HCP) a good/bad experience—why? Did this influence you attitude towards antenatal care or your attendance?

Subsequent experience of Health Care Professional (HCP) When (in weeks) did you first see a midwife? Do you think it is important to see a midwife or GP regularly during pregnancy? Have you missed any appointments with a HCP? Why? What encouraged you to attend health care services during pregnancy and what discouraged you to attend health care services during pregnancy? Experience of getting an appointment? (timing, place, interpreters etc.) Experience of getting to the hospital/clinic where your appointments were held? (difficulties e.g. transport, conflicting obligations etc.) What was your experience of talking to midwives/doctors at your appointments? (explore quality of relationship) Overall what was good and bad about the health care services offered to you during pregnancy?

The focus groups and interviews were audio-recorded, translated into English where necessary, and transcribed verbatim. Initially the transcripts from the focus groups were analysed independently by four members of the research team (RR, DS, MC, YR). The aim of this familiarisation phase was to gain an overview of the data and to begin listing key ideas and a preliminary list of themes. These researchers then met to compare and discuss identified themes. We used an iterative process whereby themes were discussed and then applied to the data. We gave specific attention to those themes which addressed the aims of the study and gathered together all relevant statements applying to each theme. The themes were refined to incorporate additional concepts. Careful attention was paid to statements that did not fit in with emerging concepts and themes. This process was undertaken independently by the researchers who repeatedly met for further discussion. A continued emphasis was placed on patterns and disconfirming statements until final agreement on the interpretation of the data was reached.

Results

Thirty women participated in the study (15 in one of six focus groups [FG] of between two and four participants and 15 in interviews). A breakdown of demographic and obstetric information by social/ethnic group is presented in Table 2.

Communication issues fell into two major themes: the quality of communication across the primary/antenatal care interface and the quality of communication within ANC (see Table 3). The participants reported their interactions with a diverse range of antenatal care providers including GPs, midwives, obstetricians and sonographers.

Communication Between GPs and Antenatal Care

All but one of the women ($) accessed antenatal care via a GP who offered shared care in collaboration with hospital or community midwives. Despite their pivotal role, women perceived that GPs had little to do with other components

Table 2 Descriptive characteristics for sample with breakdown by ethnic and social group

	N	Age (years)	Marital status[a]	Highest education qualification[b]	Previous pregnancies[c]	Gestation (months)	Date collection method[d]
English-speaking Bengali (ESB)	6	26.2	M = 6 N = 0	None = 0 GSCE = 3 A = 2 Degree = 1	P = 2 M = 4	5.2	I = 4 FG = 2
Non-English-speaking Bengali (NESB)	4	30.8	M = 4 N = 0	None = 1 GSCE = 3 A = 0 Degree = 0	P = 0 M = 4	3.5	I = 2 FG = 2
Non-English-speaking Somali (NESS)	5	30.0	M = 5 N = 0	None = 3 GSCE = 1 A = 0 Degree = 1	P = 1 M = 4	7.6	I = 3 FG = 2
High educated White British (HEWB)	8	37.3	M = 7 N = 0 (1 unknown)	None = 0 GSCE = 0 A = 0 Degree = 8	P = 4 M = 4	6.2	I = 2 FG = 6
Low educated White British (LEWB)	7	25.6	M = 3 N = 4	None = 2 GSCE = 5 A = 0 Degree = 0	P = 5 M = 2	6.1	I = 4 FG = 3
All	30	30.2	M = 25 N = 4 (1 unknown)	None = 6 GSCE = 12 A = 2 Degree = 10	P = 12 M = 18	5.8	I = 15 FG = 15

[a] M = Married/living with partner, N = Not married/living with partner [b] None = no formal educational qualifications, GCSE = age 16 qualifications (i.e. General Certificate of Secondary Education or equivalent), A = age 18 qualifications (i.e. A-level or equivalent), Degree = Bachelor's degree or equivalent
[c] P = primiparous, M = multiparous [d] I = Interview, FG = Focus group

of the antenatal service and that some did not appear to regard this as a problem that needed to be addressed (Table 4, sub-theme 1.1).

The consequences of this 'silo culture' included confusion about the appropriate first port of call in the event of a potential antenatal problem, failure to exchange clinical information with other health care professionals (HCPs) and an inability to guide women through the ANC system; all of which clearly frustrated the affected women (Table 4, sub-theme 1.2).

Communication Within Antenatal Care

There was a wide diversity in women's experiences of communication with their antenatal HCPs, although most women reported examples of both positive and negative encounters.

Experiences of Constructive Communication

Women reported many instances of constructive communication and five discrete sub-themes were identified, all of which were undoubtedly valued by the women concerned.

An Empathic Conversational Style Women found that empathic HCPs or those with an engaging style of interaction were reassuring and enhanced rapport (Table 5, sub-theme 2.1.1).

Open to Questions Openness to questions on the part of HCPs also facilitated the provision of reassurances that women needed (Table 5, sub-theme 2.1.2).

Allowing Time to Talk Women also appreciated HCPs who did not make them feel rushed during antenatal appointments (Table 5, sub-theme 2.1.3).

Table 3 Themes and sub-themes

1. Communication between GPs and Antenatal Care
1.1 GPs operate in ‘silo culture’
1.2 Consequences of silo culture
2. Communication within ANC
2.1 Constructive communication
2.1.1 Empathic conversational style
2.1.2 Open to questions
2.1.3 Allowing time to talk
2.1.4 Text message appointment reminders
2.1.5 HCPs take the initiative
2.2 Poor communication
2.2.1 Lack of description of overall pattern of care
2.2.2 Purpose of antenatal appointments unclear
2.2.3 Professional roles unclear
2.2.4 HCPs concerns not fully explained
2.2.5 Lack of due care and attention
2.2.6 Poor styles of communication
2.3 Responses of women
2.3.1 Tolerance when situations are explained
2.3.2 Proactive communication by women
2.3.3 Potential to undermine commitment to ANC

Table 4 Theme 1: communication between GPs and antenatal care

Sub-theme 1.1: GPs operate in ‘silo culture’

(i) ‘‘the GP didn’t really know how the hospitals and midwives worked. It catapults you into the hospital system and that’s it as far as the GP is concerned’’ (FG2, HEWB $2)

(ii) ‘‘[at] my first appointment with the GP, I said can you give me the right number to get through?…and the GP said I’m really sorry, I don’t know them’’ (FG2, HEWB, $2)

Sub-theme 1.2: consequences of silo culture

(i) ‘‘one day there wasn’t any movement from the baby…[my GP] told me to go to the hospital straight away…scan people (at the hospital) asked whether the GP checked using a monitor…[my GP] said we don’t have this you have to go to hospital’’ (FG4, NESB, $2)

(ii) ‘‘[My GP] said, do you have a urine sample? I hit the roof. I’ve already sent off two urine samples. Nothing was logged in the system. I started crying ‘cos I was so angry…she (the GP) said ‘oh, midwives don’t work with me, we don’t work under the same company’’’ (FG5, ESB, $2)

(iii) ‘‘I wanted to get referred back to a consultant this time [i.e. for this woman’s second pregnancy], and the GP wasn’t sure about how that would work, and she seemed to kind of say, once you’re in the system, it’s out of our hands’’ (FG2, HEWB, $2)

Text Message Appointment Reminders Proactive contact was particularly appreciated by women. This included text message appointment reminders, which are automatically sent to women’s mobile (cell) phone from some hospital-based antenatal clinics (Table 5, sub-theme 2.1.4).

Table 5 Sub-theme 2.1: constructive communication

Sub-theme 2.1.1: empathic conversational style

(i) ‘‘If they talk nicely then you feel peace…. I feel very relaxed’’ (FG4, NESB, $1)

(ii) ‘‘our first scan, she was saying, ‘look at this, and it’s all lovely’, and she seemed really excited, and they make you feel that…you’re being looked after’’ (I4, HEWB)

(iii) Referring to the reaction of staff at the Assisted Conception Unit when the woman had a positive pregnancy test: ‘‘they’re delighted when they get a positive result and you get hugs from the nurses…and your consultant comes in and sends his congratulations, and all that is very reaffirming’’ (FG1, HEWB, $4)

(iv) ‘‘[it’s] the way [the midwife] talks to me and we can laugh and joke and…I feel…really comfortable’’ (I14, LEWB)

Sub-theme 2.1.2: open to questions

(i) ‘‘[the consultant] was lovely…she was approachable, she was like, ‘is there anything else? Oh, do you want to hear the baby’s heartbeat?’’ (FG6, LEWB, $2)

(ii) ‘‘I can ask [the midwife] questions even though it could be just growing pains, it’s just [it will] put my mind at ease and let me know’’ (I14, LEWB)

Sub-theme 2.1.3: allowing time to talk

(i) ‘‘she listens to all the problems…and not like, you’ve only got 10 min’’ (FG5, ESB, $1)

Sub-theme 2.1.4: text message appointment reminders

(i) ‘‘it’s brilliant because you get that text message and you go, oh yeah, you have an appointment’’ (FG6, LEWB, $2)

(ii) ‘‘this appointment I totally forgot…and then I got the text message, and I was like, yeah’’ (I6, ESB)

Sub-theme 2.1.5: HCPs take the initiative

(i) [the midwife] said…that she’d phone me, and she did actually phone me…and we agreed the appointment time’’ (FG6, HEWB, $1)

(ii) ‘‘the midwife told me that I was small for gestational age so she arranged for me to have a scan at the hospital. I knew that midwife was helping me because she phoned me and asked how…the scan went, what they said to me and that was good because you know that she’s aware of what’s happening’’ (I8, NESS)

HCPs Take the Initiative In addition, women evidently found it refreshing when their HCP was willing to take the initiative to ensure that they would receive prompt and appropriate health care (Table 5, sub-theme 2.1.5).

Experiences of Poor Communication

A range of poor communication experiences were reported by women. These were categorised into six distinct areas of concern.

Lack of Description of Overall Pattern of Antenatal Care Some women reported that HCPs did not convey a clear overall picture of the care that they could expect to receive as they progressed through their pregnancy and

Table 6 Sub-theme 2.2: poor communication

Sub-theme 2.2.1: lack of description of overall pattern of antenatal care

(i) ‘‘you never, from the outset, have a vision of what will be happening to you at certain stages’’ (I2, HEWB)

(ii) ‘‘I asked her about my birth plan, and she just said, ‘oh, it’s too early for that, we’ll discuss that later on’’’ (FG6, LEWB, $1)

(iii) ‘‘knowing a bit more detail about what’s going to come up during those sessions,…then you’re more focused on the kind of dialogue that you need to have. Otherwise it would be easy to forget to ask a question, or to think well that maybe applies a bit later and I don’t need to find out now, but actually maybe you do’’ (FG2, HEWB, $1)

(iv) ‘‘It would really help to have a list of numbers saying, you know, this is who you phone for X, this is who you phone for Y…because otherwise you feel lost’’ (FG2, HEWB, $2)

Sub-theme 2.2.2: lack of a clear understanding of the purpose of routine antenatal care

(i) ‘‘you’d been [to] the hospital last week…you have midwife this week, you knew really, she wasn’t really going to tell you a lot, and you weren’t going to get a lot out of it’’ (FG6, LEWB, $1)

(ii) ‘‘they repeat the same thing…so it just seems pointless waiting all that time …to see the doctor whereas you know what they’re going to say because the nurse has already said it’’ (I6, ESB)

Sub-theme 2.2.3: lack of explanation about the roles of different HCPs

(i) ‘‘There’s the obstetricians and there’s midwives and there’s various groups within the obstetricians and I don’t understand how you get allocated to a consultant or what that means’’ (FG1, HEWB, $3)

(ii) ‘‘Why would I want to speak to someone who’s not that qualified, when you can speak to a consultant?’’ (I2, HEWB)

Sub-theme 2.2.4: HCPs failure to explain their concerns about possible complications

(i) ‘‘one of the doctors turned around and said, oh, my God, it’s a bit big. So what’s that supposed to mean?’’ (I6, ESB)—a woman with gestational diabetes

(ii) ‘‘Like for my 5 month scan [the midwife] said something to me, I said I don’t understand. She said something about the baby’s heart and I said I don’t understand. Then she said ‘no problem’. And then I asked her if the baby was OK, she said ‘yes’ and then they sent me for another scan. If everything is fine a person only has two scans. So I am on my fourth scan and I don’t know what is happening’’ (I15, NESS)

Sub-theme 2.2.5: lack of due care and attention

(i) ‘‘I was a bit surprised that on my notes it said that I was a smoker. I stopped smoking ages ago but nobody’s asked me about that and…I thought that they would follow up’’ (FG6, LEWB, $1)

(ii) ‘‘Then [the midwife] had written in my book that I was 31 weeks pregnant, and she started grilling me as to why I hadn’t attended the 28 week blood tests, and I’m like, well, I’m not 30 weeks, and she was ‘but it says here’, and I was like, well, yeah, you just wrote that’’ (FG6, LEWB, $2)

(iii) ‘‘that feeling that the health professionals are being quite blasé about it. Because they’ve seen so many pregnancies that are absolutely fine…and actually it doesn’t feel like that when you’re the one who is pregnant’’ (FG2, HEWB, $2)

Sub-theme 2.2.6: Poor styles of communication

(i) ‘‘[the HCP] was so rude, so dismissive, so patronizing and almost annoyed I was even there…just wanted me out of the room as quickly as possible’’ (I2, HEWB)

(ii) ‘‘the internal check-up, if you say…that you’re hurting, ‘I just have to do it’…its the aggressive way they would answer’’ (I9, ESB)

(iii) ‘‘I tried to tell them. I felt like they’re not hearing me’’ (I9, ESB)

(iv) ‘‘tick tock, time is getting on…lets get you out of here so we can go home’’ (FG6, LEWB, $2)

‘‘Most Bengali women, they can’t speak English, and…I see that [Bengali women are] treated bit different…[midwives] are quite polite and nicely speaking to the English ladies…but I can see it’s different treatment [towards Bengali women]’’ (I9, ESB)

HCPs did not clearly explain when would be the appropriate times to discuss particular aspects of care (Table 6, subtheme 2.2.1, quotes i. & ii.). Women expressed a desire to be provided with information that would help them to navigate the system (Table 6, sub-theme 2.2.1, quotes iii. & iv.).

Lack of a Clear Understanding of the Purpose of Routine Antenatal Care The purpose of each antenatal appointment was often unclear and the apparent duplication of visits frustrated women (Table 6, sub-theme 2.2.2).

Lack of Explanation About the Roles of Different HCPs The roles of the different professional groups were unclear to some women, some of whom assumed that it was preferable to see an obstetrician, even if they were a ‘low risk’ pregnancy (Table 6, sub-theme 2.2.3).

HCPs Failure to Explain Their Concerns About Possible Complications Sometimes women realised that the HCP was alerted to a potential problem with their pregnancy and felt apprehensive when the HCP did not explain their concerns to them (Table 6, sub-theme 2.2.4).

Lack of Due Care and Attention Women perceived that some HCPs lacked a woman centred focus. This was demonstrated by a failure to check the accuracy of basic

clinical data and by superficial attention being paid to individual women (Table 6, sub-theme 2.2.5, quotes i. & ii.). Some women assumed that this was secondary to a failure to appreciate women's perspective regarding their pregnancy (Table 6, sub-theme 2.2.5, quote iii.).

Poor Styles of Communication Women reported that the HCPs interactions with them sometimes tended to be discourteous, abrupt or lacking in compassion (Table 6, sub-theme 2.2.6).

Responses of Women

Women valued the reassuring nature of effective communication. In addition, three other main themes emerged. The first concerned the tolerance demonstrated by women, in often stressful situations, when they were provided with clear information about their situation. The second highlights the practical responses of some women to poor communication and the third theme illustrates the potential for poor communication to undermine women's commitment to their ANC.

Tolerance When Clinical Situations are Communicated Clearly Women reported their preparedness to be patient during stressful circumstances, provided they were given clear explanations about the situation they were in (Table 7, sub-theme 2.3.1).

Proactive Communication by Women Some women reported that they needed to initiate communication themselves. This was particularly evident in terms of making appointments, but also occurred in relation to clarifying correct procedures relating to diagnostic tests (Table 7, sub-theme 2.3.2).

The Potential to Undermine Women's Commitment to ANC Some women reported a reluctance to attend appointments which appeared to serve little purpose or to meet their needs. However this did not translate into actual failure to attend appointments (Table 7, sub-theme 2.3.3, quotes i. & ii.). Others reported that they chose not to attend for a routine ultrasound scan. There appeared to be misunderstandings about its value and safety (Table 7, sub-theme 2.3.3, quotes iii. & iv.).

Discussion

Our study shows that, within a single Trust, women's experiences of communication varied considerably. With respect to primary care, women's major issue related to GPs' lack of knowledge about the maternity services provided by the Trust. The women perceived that their GP's were unconcerned by the lack of communication between primary and antenatal care. However we did not interview the GPs themselves and data from other settings show that GPs are concerned by the presence of professional silos and believe that communication barriers undermine GPs' credibility and by extension, their relationship with patients [22]. This accords with our finding of frustration amongst the women affected.

Table 7 Sub-theme 2.3: responses of women

Sub-theme 2.3.1: tolerance when situations are clearly explained

(i) ''[the sonographer] said, I'm not going to talk to you now, I need to do what I need to do…and then I'll go through it with you afterwards…and so because she'd said that, it was all right when she was doing all her stuff…. I wasn't sat there thinking 'oh, God, is it all right?''' (FG6, LEWB, $1)

(ii) ''They said, at the moment there's no doctors on the ward and we've got six ladies waiting…they were very sympathetic and saying…we're really sorry but you might have to wait a couple of hours to have your scan. I said that's fine'' (I4, HEWB)—waiting for an unscheduled ultrasound following a 'little scare'

Sub-theme 2.3.2: proactive communication by women

(i) ''There were so many occasions when I had to chase or phone up'' (FG2, HEWB, $2)

(ii) Referring to the lack of explanation offered about the procedure for glucose tolerance testing (GTT): ''no one tells [women] that they have to knock on the door, no one tells them they have to time their own hour and go back…and if there's a massive queue…people would probably just wait and then it could be 2 h…and then they've screwed all the results up.'' (I2, HEWB)

Sub-theme 2.3.3: potential to undermine women's commitment to ANC

(i) ''There would be this part of me that thinks, can I really be bothered to go?…at a time of life when you're quite vulnerable…you want to see someone who is going to reassure you…if you don't get that then I don't see point in going'' (FG6, LEWB, $1)

(ii) ''when I've rung [the HCP] it's just like you're getting fobbed off, and you don't want to ring back after that.'' (I5, LEWB)

(iii) ''I tend to always miss my first scans…[I] join the process late'' (FG3, NESS, $1)

(iv) ''I missed an appointment…the early scan is not to be gone to, Somalis…they said it is not good to go, if you go there will be problems, they will drop the baby from you'' [a metaphor for a miscarriage] (FG3, NESS, $2)

Within antenatal care, the characteristics of communication that were particularly highly valued by women were the ability of HCPs to demonstrate empathy and proactive contact. Women assessed the empathic content of communication on three dimensions: the extent to which HCPs were judged to be compassionate, to be willing to engage in dialogue, and to genuinely attend to the circumstances and needs of individual women. Our results are in line with previous research which reports women want providers

who are caring and reassuring [14], and who are able to engage with them [23]. Women also appreciated the use of text messaging to remind them of appointments. However this service was not universally available across the Trust and highlights the need to increase the use of technologies in the NHS [24].

For women in our study, empathic communication reduced anxiety, facilitated a constructive relationship with the HCP and allowed effective information exchange. Similar findings have been reported in other healthcare settings [25] where proactive communication was interpreted by patients as indicating that their concerns were being taken seriously.

Three components of ineffective communication were identified. First, specific aspects of inadequate information provision were reported. These included a need for better information about the overall configuration of ANC; the purpose of each appointment; the distinction between different HCP's roles; and how to access advice and care should unforeseen concerns arise. These results reflect national findings [7, 13, 26] which, though they report generally positive perceptions of communication, also highlight problems relating to the provision of information in a way that women could understand and uncertainty about where to go for advice. Second, women reported a lack of person centred dialogue. This occurred during the exchange of routine information and also when there were potential problems with the pregnancy. The importance of being sensitive to individual needs has been noted elsewhere. A study of low income women described inattentiveness towards their circumstances and to the frequent challenges faced by them [23]. Another study, of Somali women who spoke some, but not fluent English [27] reported a lack of realisation amongst midwives with respect to the extent to which women considered the language barrier to be a problem and resulted in their needs not being met. Finally, in our study and also in line with previous research, some HCPs demonstrated communication styles which left women feeling rushed, ignored or dismissed [23, 28].

Amongst women who encountered poor communication, two distinct response patterns were identified. Some women initiated proactive communication such as 'chasing up' antenatal appointments. Others became disinclined to be proactive where the benefits were unclear or where women felt rebuffed by previous attempts to engage with HCPs. These response patterns reflect two dispositional coping strategies, problem-focused and emotion-focused coping [29]. Problem-focused coping includes planning, active coping and instrumental support-seeking, while emotion-focused coping includes mental or behavioural disengagement [30]. People tend to use problem-focused strategies when they believe the circumstances are changeable and emotion-focused strategies when they believe a stressful situation is unalterable [29]. Previous authors have reflected upon social variations in the propensity to be resigned to the perceived status quo [31]In our sample, the numbers of women in each social group were too small to draw any robust conclusions, however highly educated White women gave the clearest examples of problem-focused coping, while low educated White women and non-English-speaking women gave the clearest examples of disengagement. These observations require validation in a larger study.

Methodological Issues

A key strength of this study lies in the social diversity of the sample recruited. Our aim was to recruit women with a variety of experiences of antenatal care and to reflect as far as possible, the social and ethnic characteristics of users of care. As with other qualitative research, our sample size was small and we are careful to guard against making unwarranted conclusions. However our methods were robust and our results are consistent with other research. This suggests that our results will be transferable to other settings.

A limitation of our study was our inability to span the full spectrum of attenders, including those who do not access care. We were therefore unable to explore the extent to which the quality of communication influences some women's decisions not to attend. Nevertheless, even in our sample, some women reported a lack of incentive to attend which was in part a consequence of poor communication. A second limitation was that, despite offering incentives and our flexible methods of data collection, we were unable to recruit sufficient women in each social group to allow us to compare the experiences of affluent compared with socially disadvantaged women and of Bengali, Somali and White women. Other research has highlighted the influence of patient's socioeconomic status and ethnicity on doctor-patient communication [32, 33]. However, given the number of women in each social group, it is perhaps unsurprising that few clear differences emerged in our study. Had we recruited larger numbers of women to each social and ethnic group, we may been able to draw conclusions about cultural influences on patient-provider interactions that were suggested by our respondents. For example there was an indication that HCPs were less empathic, more terse and less likely to provide helpful explanations when interacting with minority ethnic women. However this potential theme would require further exploration amongst larger groups of white and minority ethnic women. Finally, the non-English speaking women often knew the interpreters well. All interviews were translated and transcribed independently in full. Whilst we can therefore be confident that the

translations represented an accurate reflection of what the women said, we cannot know whether women would have provided different responses had the interpreters been unknown to them. Despite this limitation, the non-English speaking women appeared to be willing to speak candidly about their experiences.

Conclusions

Policy makers emphasise the need to improve communication in antenatal care. However, little attention has been given to how these policies are practically applied [34]. Our findings suggest specific improvements in communication need to occur both at the primary/antenatal care interface, as well as within ANC. GPs need to be more effectively integrated into ANC. The use of technologies such as text messaging should be expanded and ANC professionals would benefit from communication training which may include use of skills such as active listening [35] and which should specifically address the issues highlighted in this study.

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