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WOMEN'S EXPECTATIONS AND EXPERIENCES IN MATERNITY CARE: HOW DO WOMEN CONCEPTUALISE THE PROCESS OF *CONTINUITY*?

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A B S T R A C T

Objective: to gain an understanding of how women conceptualise continuity of maternity care.

Design: a qualitative study involving in-depth semi-structured interviews and thematic analysis.

Setting: a range of urban and rural public hospitals in New South Wales, Australia.

Participants: 53 women aged 18-44 years (median age 27 years) receiving maternity care in 2011 - 2012.

Findings: responses from women suggested five types of continuity: continuity of staff, continuity of relationship, continuity of information, continuity across pregnancies, and continuity across locations. The types of continuity differed by parity and location.

Conclusion and implications for practice: continuity of maternity care has a variety of meanings to women. If healthcare providers are to commit to providing woman-centred maternity care it is important to recognise the diversity of women's experiences, and ensure that systems of care are flexible and appropriate to women's circumstances and needs.

Keywords

Continuity, Conceptualise, Relational care, Maternity care

Introduction

Continuity is defined as a state or quality of being continuous, unbroken, without cessation, and consistent existence or operation of something over a period of time (Macquarie, 1988). In health, the concept of *continuity* emerged in the 1940s, shifting the emphasis from disease to patient and their family and community, and extending treatment from hospital to also include home (Joint Committee of the NLNE, NOPHN on the Integration of the Social and Health Aspects of Nursing in the Basic Curriculum, Carn, Subcommittee to Study the Hospital Referral of Patients for Continuity of Nursing Care, & Frost, 1947). The introduction of family practice as a new discipline in the 1960s in the US and 1970s in Australia and England considered *continuity* of care to be one of its defining characteristics (Fisher, 2008; J. W. Saultz, 2000; The Kings Fund 2011.). It particularly emphasised *relational continuity*, that is, the importance of an ongoing relationship between a patient and one or more care providers (J. Saultz, 2000), characterised by personal trust and responsibility (Baker, et al., 2007; Freeman & Hjortdahl, 1997). Today, the healthcare system promotes *continuity* as a core organisational value affected by environmental influences, communication, patient, professional and system factors (Sparbel & Anderson, 2000).

Continuity of care is distinguished from other characteristics of care by two core elements: care over time (Haggerty et al., 2003; Rogers & Curtis, 1980); and a focus on individual patients. Common to every discipline are three types of continuity - *informational, management and relational* (J. Saultz, 2000). *Informational continuity*

uses information which can be disease or person focused as the common thread linking care from one provider to another and from one healthcare event to another (Haggerty et al., 2003). *Management continuity* requires management from several providers who could otherwise work at cross purposes, especially important in complex or chronic diseases (Reid et al., 2002). *Relational continuity* builds on accumulated knowledge of patient preferences and circumstances that is rarely recorded in health records, and interpersonal trust based on experience of previous care and positive expectations of future competence and care (Guthrie et al., 2008).

Continuity of care is considered a critical dimension in maternity care (Boulton et al., 2006; Commonwealth of Australia, 2010; Homer et al., 2002; Hundley et al., 1995). Mostly, *continuity* in maternity care is conceptualised as a woman having contact with a limited number of health care providers during the childbirth process (Commonwealth of Australia, 2010; NSW Health Primary Health and Community Partnerships, 2010). It is seen as a mechanism for overcoming fragmentation (Green et al., 2000), inconsistency (Brown & Lumley, 1994), long waiting times (Green et al., 2000) and insensitive caregivers (Garcia et al., 1998). In Australia, current maternity care policy is grounded in a commitment to woman-centred care and a philosophy aimed at “ensuring that a woman knows her maternity care provider/s and receives care from the same provider, or small group of providers, who are responsible for providing the care that is appropriate, safe and effective, based on her identified needs and individual circumstances” (NSW Health Primary Health and Community Partnerships, 2010). This paper explores Australian women’s views about

continuity in maternity care, and is part of a larger study that investigated women's understanding and experiences of care during pregnancy and birth.

Methods

A qualitative study design was employed to investigate how women understand and experience their maternity care, and its impact on their personal circumstances. Ethics approval for the study was granted by the Northern Sydney Central Coast Area Health Service Human Research Ethics Committee.

Data collection

Semi-structured interviews were conducted with pregnant or recently pregnant women presenting for care at various public maternity care facilities in New South Wales (NSW), Australia: in one large tertiary hospital, one regional hospital and two large rural hospitals, one with outreach clinics in six remote communities. Women were eligible to participate in the study if they were receiving or had recently received maternity care as an inpatient or outpatient, at least 18 years of age, and able to understand and read English. Purposive variation sampling was used to select information rich subjects who would provide a broad range of perspectives regarding maternity care received across the continuum of antepartum and postpartum care (Patton, 2002). Variation in maternal age, parity, obstetric risk status, socio-economic status, and urban versus rural residence was sought. Sampling continued until the point of saturation had been achieved (Morse, 1995).

Between February 2011 and February 2012, eligible women identified in

consultation with local midwives and/or obstetricians were provided with information about the project and invited to participate. Fifty-three women consented to in-depth interviews; no woman declined. The average length of the interview was 40 minutes (range 30 - 45 minutes). Interviews were intentionally semi-structured, and conducted in hospital by the same researcher (MJ) either in the second or third trimester of pregnancy, in very early stages of labour, or in the postpartum period up to 3 weeks post-birth. The interviews were guided by the following key questions:

- 1) Can you tell me how you came to be here today?
- 2) Can you tell me about your relationship with health professionals over the course of your pregnancy?
- 3) Can you tell me about your experience of attending health facilities?
- 4) How have your expectations been met or changed as a result of the care you have received?
- 5) What 3 aspects would you see as most important for delivery of maternity care?

All interviews were digitally audio recorded, transcribed verbatim and checked for accuracy by the researcher.

Data analysis

An iterative process of data analysis shaped ongoing data collection. This allowed the researcher to refine questions, pursue emerging avenues of inquiry and look for deviant cases. The data were managed and analysed using NVivo 9.2 (QSR International, 2010). Analyses of interviews were conducted by three study authors (MJ, JF, RF). Consistent with an inductive approach (Glaser & Strauss, 1967), transcripts were initially read in full and analysed using open coding techniques

whereby each meaningful segment of text was assigned a conceptual code. An agreed coding system was developed, based on themes that emerged following individual review of 12 transcripts by MJ, RF and JF (Strauss & Corbin, 1998). The coding system was applied to all 53 interviews and each interview was independently coded by at least two of the authors. MJ's experience as a practicing midwife, registered nurse, genetic counsellor and clinical researcher in the public hospital system also guided the data collection and analysis. Acknowledgement of and reflection on this researcher's views on maternity service delivery was recorded in field notes and included in the analysis (Holloway & Wheeler, 1996).

Findings

Of the fifty-three women interviewed, 26 (49%) were primiparous and a median age of 27 years. Women lived across urban (17%), regional (28%), rural (40%) and remote (15%) parts of NSW, and experienced different models of care, mostly hospital-based (60%). Fifteen percent of women received private obstetric care and 23% were cared for by a team of people including GP, obstetricians and/or midwives. Half of the interviews were conducted postpartum and among these women, the majority (75%) followed spontaneous vaginal birth.

Thematic analysis of entire interview transcripts revealed five important elements of maternity care: woman-focused care, staff qualities, systems and facilities, family-focused care and continuity. Two-thirds of women referred to aspects of continuity during their interviews, however when asked to nominate the three most important issues for delivery of maternity care, only one-third of women mentioned continuity

issues (higher proportions of women mentioned staff qualities, woman-focused care and systems and facilities). Given the current maternity policy focus on continuity of care, the frequent mention of aspects of continuity in the interviews, consistent with being at different stages of the antepartum and postpartum care continuum, the study authors sought to analyse how women conceptualised continuity. Analysis of interviews indicated five types of *continuity* being spoken about by women: *continuity of staff*, *continuity of relationship*, *continuity of information*, *continuity across pregnancies*, and *continuity across locations*. Other aspects of continuity or discontinuity unique to individual women also arose, for example, for one woman, the closure of a maternity service in town forced her emergency transfer to another maternity hospital 765km from her home because the air ambulance was unable to land at the closest birthing hospital due to fog. These unique situational aspects of *continuity* are not explored further here.

Continuity of staff

The majority of women commented on the importance of healthcare provision occurring in the same place, with the same healthcare providers (including doctor, midwife and/or student midwife). More women in rural than urban settings commented on continuity of staff. Some women believed that *continuity of staff* was essential for effective monitoring of their pregnancies:

“I like just to have one on one contact with the one person that knows everything, is - what’s going on with me, and so we don’t get mixed information with other people.” (W16 multiparous postpartum rural)

Continuity of staff did not necessarily describe a single person. For some women familiarity with a group of caregivers was important:

“So I met with the community midwives. You could see a different midwife every time you go to an appointment, so I met about eight of them, and that was really good...when I started my labor...I had practically met all of them.” (W42 primiparous postpartum regional)

Women recognised that their ability to choose a consistent staff relationship could be limited by their geography:

“So I was quite into my pregnancy by then. Everything was established, but the reason I didn’t choose an obstetrician closer to home was because the choice was just lacking.” (W45 primiparous antepartum rural)

or medical circumstances:

“I wasn’t too happy at first when I had to be transferred [from primary midwife care] but then after a few days I got used to the idea because I was actually born in this hospital anyway, so it’s nice to have my baby where I was born.” (W07 primiparous antepartum urban)

Continuity of relationship

Some women emphasised a desire for an ongoing personal relationship with a single healthcare provider. They characterised this relationship in terms of trust, responsibility and the caregiver’s familiarity with their circumstances or story. Many of the comments on *relationship continuity* were made by primiparous women:

“We did choose it [caseload midwifery]...it was a really personal experience. I really wanted to have that sort of care and nurturing of a midwife or a doctor.”

(W08 primiparous antepartum urban)

Knowing a caregiver was seen by some women as central to personal care and the promotion of open communication:

“[T]o see that one face, and know that you’re going to understand what they’re telling you and they understand you a little more, ‘cause they’ve got to know you...I think knowing somebody a little better, is a lot better than not knowing them at all.” (W15 multiparous antepartum rural)

Conversely, women who did not feel known by their caregiver saw this as a disadvantage:

“Probably not having that rapport with a particular person or with a couple of people...all I wanted, was just someone that I could go, ‘Yeah...I’ve seen that person before’. And it didn’t end up happening like that. So that was the most challenging thing.” (W14 primiparous postpartum remote)

Continuity of information

Women stressed the importance of each healthcare provider having access to their health information. Continuity and consistency of information provided by their healthcare providers during pregnancy was also seen as important, particularly among primiparous women. For some women, *continuity of information* was best provided by having a single caregiver:

“Having the same person throughout the pregnancy definitely was important...one that knows the health record of myself and the babies so you

don't have to get switched around all the time and then have someone make a mistake. You don't want that." (W51 multiparous postpartum rural)

For others, *continuity of information* was not dependent upon the same caregiver:

"Look, it would be better to see the same person. I just hope that every time you do see someone, they're thorough with their notes so the next person knows, you know, what happened last time." (W03 primiparous antepartum urban)

In complex pregnancies, women spoke about the need to be kept up to date:

"I have two sets of - well, I have all the obstetric doctors and then I've got the renal doctors... Being informed constantly and just having trust in your doctors I think is the most important thing; believing that they know what they're talking about." (W11 primiparous antepartum urban)

Some women perceived that a team approach to care sometimes resulted in inconsistent information being provided:

"I know everybody has their own different opinions... consistency is very, very hard when you have no idea what you are doing and you've got someone coming and telling you something else because that's what they believe." (W14 primiparous postpartum rural)

Continuity across pregnancies

Continuity across pregnancies emerged as a distinct concept particularly among multiparous women living in rural and remote settings. Women believed continuity of caregiver *across pregnancies* affected the management of their current pregnancy.

One woman travelled 10 hours in her last pregnancy to have the same doctor at the time of delivery:

“My first delivery was an emergency caesarean after 14 hours of labor. And I wanted to have a vaginal birth for the second. So I believed I would get the best chance at a trial by labor if I went back to the same doctor that I went to the first time, which I did. And we had an uneventful drug-free, no problem second labour, yeah.” (W25 multiparous postpartum remote)

In another case, a lack of familiarity with a woman’s history was seen to affect the kind of advice and information provided:

“So each time you come over you’ve usually seen a different doctor. So like you had one doctor saying that the bubby was too small and they were a bit concerned - then I’d actually seen the Specialist that other week. And he said to me, ‘Look. I’m sure everything’s fine,’ cause he’d been with me throughout the other two pregnancies and he was pretty sure that everything was fine.” (W28 multiparous postpartum rural)

Continuity across locations

Continuity across location related to the ability of a health care provider to “follow” a woman across different locations, and was specific to women who were transferred between hospitals and those who had to leave their communities to give birth in a referral centre. Women believed this type of continuity provided consistent management of their pregnancy. Women linked locational continuity to feeling confident in the care provided and feeling reassured about a safe and healthy outcome for themselves and their babies.

Women in rural and remote settings developed their own solutions to lack of locational *continuity*, for example, by having shared care between a GP and or midwives and specialist obstetrician:

“I went under the care of the GP and midwives in town...I think fortunately in town having a GP that does obstetrics is a wonderful gift for us.” (W25 multiparous postpartum remote)

One woman suggested she would have had the best of both the private and public health care system if her private obstetrician had visiting rights at the public hospital to which she was transferred at 24 weeks:

“But I mean the best of both worlds would have been having my obstetrician here [public hospital], giving birth and staying here [laughs].” (W02 primiparous antepartum urban)

Discussion

Continuity of care is important to women during pregnancy and childbirth, but it is more than the provision of one-to-one care. Women in our study highlighted the importance of relational and informational *continuity*, previously identified by others (Baker et al., 2007; Freeman & Hjortdahl, 1997; Green et al., 2000; Haggerty et al., 2003; Hatem et al., 2008), but also the importance of *continuity across pregnancies* and *across location*, reflecting not only relational aspects but also systems of management continuity.

In terms of relational continuity, *continuity of staff*, *continuity of relationship* and *continuity across pregnancies* can be conceptualised as different expressions of a

desire to know and be known by caregivers (Homer et al., 2002). Personal, caring and co-operative relationships with maternity care professionals are basic to mothers feeling good about their birth experience (Howarth et al., 2011). Women in our study also viewed such relationships as contributing to the effective monitoring of their pregnancies. Primiparous women were more likely to identify the importance of relationship during pregnancy (Dahlen et al., 2008); multiparous women emphasised the importance of these relationships continuing across pregnancies, particularly for women with a complex pregnancy history (Fleming et al., 2011). A woman's desire for *continuity across pregnancies* is a likely extension of wanting relational aspects and systems of care *continuity* including good communication within the system, health providers and consistent policies (Green et al., 2000; Haggerty et al., 2003; Lees G, 1997). Rural women were more likely to report a desire for *continuity of staff* than urban women which may reflect the experiences and perceptions of limited choice regarding place of delivery in rural settings (Kornelsen & Grzybowski, 2006). Women in both urban and rural settings commented on a desire for *continuity across locations*, a finding that has not been reported elsewhere.

Primiparous women in particular commented on a desire for *informational continuity* in both pregnancy and postnatal care. Women recognise the importance of accurate updated health records that are accessible to all health care providers (Fraser, 1999). For women with a complicated antenatal course, this was particularly important. The women in our study also spoke of the inconsistency of advice that came with having multiple care providers, and the perception that conflicting information from providers suggested a mistake, threatening consumer trust (Sheppard et al., 2004).

A recent meta-synthesis relating to patients' perceptions of *continuity* of care in non-maternity care settings concluded that variations in the perceived importance of *continuity* appeared to depend on both individual and contextual factors which should be taken into account during healthcare provision (Waibel et al., 2012). Clearly, the concept of *continuity* of care crosses organisational and disciplinary boundaries. However, efforts to facilitate delivery of *continuity* of care have been complicated by lack of consensus amongst providers and health organisations on the definition of *continuity* (Haggerty et al., 2003). The present study supports the importance of relational and management continuity, but also suggests factors unique to women's personal preferences, pregnancy history, stage of pregnancy and geographical location may play a role in continuity of maternity care.

The strength of this study is the relatively large sample of 53 women in urban, regional, rural and remote areas, enabling capture of a broad range of perspectives across different pregnancy experiences (primiparous, multiparous) and at various stages of the pregnancy continuum (ante-partum and post-partum care). However, like all qualitative studies, the authors recognise the limits on the generalising ability of the results. Whilst this study drew on a sample of predominantly Australian born, English-speaking women, future research possibilities present for Indigenous, non-Australian born and non-English speaking participants.

Conclusion

Women in this study spoke of *continuity* of maternity care in numerous ways and with differing meanings. Most of the concepts of *continuity* identified in women's interviews related to a desire to know their caregiver and have someone caring for them who knew their story. If healthcare providers are to commit to providing woman-centered maternity care it is important they recognise the diversity of women's experiences and ensure that systems of care are flexible and appropriate to women's circumstances and needs.

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