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# Patient-Centred Care in Maternity Services

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Additional information is available at the end of the chapter

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## Abstract

Providing patient-centred care (PCC) is one of the goals described by the Institute of Medicine (IOM) to deliver quality of care. Across several interventions described in the literature, there is no clear consensus of one that will best fit the diversity of women coming to seek care in maternity services and across the variety of healthcare providers (HCPs) who provide that care. A reason for that may be the lack of consensus about the model of care to adopt for maternity services reveals a neglected area of research. Managing quality of care should also mean considering the best model of care in practice for all women, incorporating the core and legitimate attributes of maternity care.

**Keywords:** patient-centred care, maternity services, midwifery, women-centred care, women's health

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## 1. Introduction

### Maternity care

Maternity care systems encompass the structures, a diversity of healthcare providers in their expert field of practice and policies that provide antenatal, intrapartum and postnatal care to women and perinatal care to babies. Similar to general health systems, maternity care has evolved over time, but further improvements still need to be made in the future to meet the challenges posed by changing population needs and to increase the involvement of women in their care [1]. The unique feature of maternity services is that the population is predominantly healthy in comparison to other hospital services. Quality of care delivered during pregnancy, labour and the postnatal period refers to the six elements described by the Institute of Medicine (IOM) [2], i.e. (1) safe, (2) effective, (3) patient centred, (4) timely, (5) efficient and

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(6) equitable. However, it would be too simplistic to believe that poor quality of care concerns only low- or middle-income countries. For example, in the Mother's Index 2013, it is of note that some high-income regions, such as certain states in the USA, have a higher infant mortality rate than less wealthy countries outside the USA [3, 4].

IOM's quality criteria of safety and effectiveness to improve maternal and foetal outcomes have been a primary target of research for many years [5, 6]. By contrast, patient-centred care (PCC) is just emerging on the maternal and newborn health agenda, and policymakers are only now beginning to address PCC as a dimension of quality of care [7]. The perinatal period is often associated with feelings of anxiety and sometimes even depression [8]. Women across the spectrum of maternity care described the importance of **psychological well-being** and the support received by healthcare providers (HCPs). Anxiety was described in relation to fertility treatment [9], during maternal complications, such as diabetes or high blood pressure [10], when the care was transferred from a midwife to an obstetrician [8], in deprived groups of women [11], or during physiological antenatal, intrapartum and post-natal care<sup>1</sup> [12]. It is important to note that women present various levels of anxiety, regardless of complications or not during the pregnancy. Nevertheless, when anxiety occurred, all women highlighted that continuity by the same HCP or the same group of HCPs (midwives in these articles) helped to build trust and confidence to disclose the origin and the symptoms of anxiety [12].

Women highlighted also the importance of meeting their **care preferences**. In a large questionnaire survey, Baas et al. [8] identified women's desire to receive individualised care as being related to receiving information in a different timeline and through the same HCP. Stevens and Miller [13] linked women's care preferences to the form of communication employed by the HCP, either directive or non-directive. They highlighted that directive information (and not the full options of care) does not meet women's own preferences and specific needs. Similarly, Wickham [14] mentioned how continuity of the HCP was important for many women. This suggests that care should be shaped around women's preferences and needs related to their own values and beliefs. Thus, a directive form of communication with prescriptive information or through the discontinuity of the care provider cannot be considered as responding to women's needs, and a discussion of the subject at an appropriate time is more appreciated and perceived as effective.

By contrast, **communication and information** were highlighted as processes to deliver these components of care. Communication with HCPs was presented as an element to improve the knowledge of the women and to reach a shared decision. How to communicate information was described as the way in which it is possible to influence women's ability to choose between options. Gee and Corry [15] highlighted the importance of women to gain further

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<sup>1</sup>This chapter referred to physiological adaptations in pregnancy which are part of the normal process in pregnancy and are mainly in related to (1) cardiovascular, (2) respiratory, (3) renal and (4) biochemical and endocrine changes. Many of these physiological adaptations could be perceived as abnormal in the non-pregnant woman [84]. Pathological conditions during pregnancy are relatively common. The alteration in maternal physiology occurring in pregnancy may affect the pregnancy and the baby [85].

knowledge about their pregnancy and options of care in order to reduce unnecessary tests and interventions. The timing of delivery of information, considered as either too early by some or too late for others, was an issue for the women who did not feel that they had the necessary or individualised information in order to process the situation and make decisions [15, 16]. Furthermore, in a large survey conducted by Attanasio and Kozhimannil [10], women from ethnic minorities (black and Hispanic) addressed having communication issues with HCPs and of being discriminated against because they were uninsured. By contrast, social and deprived groups looked after by a group of midwives (case-load midwifery) expressed their satisfaction with care by their perception of being the centre of attention and building strong relationships with HCPs.

In addition, **case-load midwifery** was highlighted as a process to deliver continuity of care. In her brief report, Wickham revisited the components of continuity of care published by Freeman et al. [17]: (1) management continuity, (2) informational continuity and (3) relationship continuity. Wickham [14] highlighted the importance of the continuity of the HCP as part of a relational continuity. In case-load midwifery, women are allocated to a group of midwives with a primary 'known' midwife, therefore ensuring continuity of carer during the episodes of care. Case-load midwifery was mentioned in several papers reviewed (e.g. a group of midwives [six to eight midwives] who deliver care to a group of women with low and mixed levels of risks at the beginning and during pregnancy, a group of midwives providing antenatal care group sessions to women or groups of midwives for vulnerable women only). In a comparative study of women using case-load midwifery versus standard care, McCourt [18] specifically addressed women's feeling of control and how a strong relationship with the midwife contributed to improve maternal outcomes with fewer interventions during labour (e.g. episiotomy, epidural). Even when complications occurred, the midwife remained a major provider of maternity care and was not withdrawn from care provision. Similar findings were reported [8, 19] who noted the importance of maintaining the named midwife in the continuum of care in relation to psychological well-being, parenting skills and preparation for childbirth. In the physiological context, Overgaard et al. [20] found also that in a freestanding midwifery unit for women with no complications antenatally and during labour, a higher satisfaction of care was reported compared to a traditional labour ward because of the presence of midwives attentive to emotional needs and care preferences.

Therefore, a lack of consensus on the **choice of the model of care** can hinder the further development of quality care. A literature review performed systematically on 'women-centred care' and 'patient-centred care' (five databases searched and additional book review, cross referencing, specialised websites and journals for the search on 'patient-centred care') appraised several models of care for maternity services that were used. Different models of care named were PCC including five to seven domains, women-centred care (WCC), person-centred care, the linguistic model of patient participation in care, centring pregnancy or no model of care. Each model of care has its own definition and focus: (1) PCC encompasses information, communication, emotional support, respect of patient values [20] and 47 standards of outcomes [21]; (2) WCC stated that HCPs should integrate women's preferences and needs into the medical and social characteristics of care [8, 13, 14]; (3) person-centred care was defined with the importance of having someone fully available for them, receiving personalised care, with

consistent information [11]; (4) the linguistic model of participation includes the components and processes contributing to patient participation [22]; and (5) centring pregnancy involves a small group of midwives who provide prenatal care to a group of 10–12 women during pregnancy [19]. Wiig et al. [23] highlighted the challenge of using the same definition of quality and its components across the different levels of the systems from micro- and meso- to macro-systems to support quality improvement at all levels of the health systems.

The lack of consensus about the model of care to adopt for maternity services reveals a neglected area of research. Managing quality of care should also mean considering the best model of care in practice for all women, incorporating the core and legitimate attributes of maternity care.

## 2. Models of care and maternity services?

### Women-centred care

One of the most commonly used models within maternity service policies is WCC and is viewed as the cornerstone of the partnership between the midwife and the woman [24–27]. The women-centred philosophy of care emerged after a set of modernising reforms of the NHS and focus on the individualised needs and with the expectation that healthcare professionals would work in collaboration with the women to meet their needs [28]. Within maternity service provision of care, providing WCC would mean that the diversity of HCPs providing maternity care are trained and have the required skills and expertise to meet the women's individual needs.

Women-centred care has been closely linked the midwifery practice, as most of the women have a midwife as their primary health care provider throughout pregnancy, labour and the postnatal period. Whilst the midwife is expert of the care of uncomplicated pregnancies, she also provides a pivotal role in coordinating the journey through pregnancy for all women [29].

The RCM contributed to the developing philosophy of 'woman-centred care' and stated that it is the term used '[for a philosophy of maternity care] that gives priority to the wishes and the needs of the user, and emphasised the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility' ([30], p. 1). The UK and Australian Departments of Health and the Australian College of Midwives also recommend this model of care for maternity services [31–33]. Leap described the wider concept of WCC as a concept that includes the need to address women's emotional, physical, psychological and cultural need and expectations with continuity and control over the care delivered by a single or a group of HCP [34]. This addresses that relationship between the woman and the woman is the key component of the 'women-centred care' which incorporated respectfulness and sensitivity of the midwife [35]. Developing on the idea that WCC was closely linked to midwifery practice, women-centred midwifery was presented by as [36]:

- Focuses on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals
- Recognises the need for women to have choice, control and continuity from a known caregiver or caregivers
- Encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself
- Follows the woman across the interface of community and acute settings
- Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations
- Recognises the woman's expertise in decision-making

According to the RCM [37], midwife-led care is the key to achieve a direct link with the defined scope of WCC. The RCM [37] also emphasised that to truly achieve WCC, it needs to be led by midwives through the care they deliver during uncomplicated pregnancies, birth and postnatal care. Similarly, some international definitions of WCC also place an emphasis on uncomplicated pregnancies and normal birth [32, 38]. This has been defined as the care provided by midwives who act as 'the lead professional in the planning, organisation, and delivery of care given to woman (who are healthy and at low risk of complications) from initial booking to the postnatal period' [39]. If, as some professional bodies suggest, midwives can only deliver WCC in the context of uncomplicated childbirth, then it would be exclusive to this discrete group, thus excluding this model of care from a significant and growing proportion of women who have or develop complications or risk factors. However, in the UK, we know that midwives do provide care to *all* women regardless of risk and are often the coordinators of care when there is multidisciplinary/multi-agency involvement. More recently, evidence has shown that WCC has been applied in some services to women who are at high risk of obstetric complications, and there have been demonstrable benefits [28, 40]. This application of WCC reflects the contribution midwives make to women's care despite the care not being *clinically led* by a midwife.

It is estimated that 40% of women are not suitable for midwife-led care at the onset of pregnancy [41], and therefore this proportion of women would not benefit from a WCC model. Furthermore, in clinical situations or countries where healthcare professionals other than midwives are the primary care provider of pregnant women (e.g. family physician or obstetrician), it is not clear whether WCC can be still offered to them [39].

In the process of current identification of WCC, midwifery has been named as being the cornerstone of WCC. In the 1990s, childbirth was becoming 'hypermedicalised', relying more and more on technology, and intervention rates were increasing rapidly and particularly the caesarean section rates. A parliamentary enquiry then determined 'the extent to which resources and professional expertise were used to achieve the most appropriate and cost effective care of pregnant women and delivery and care of newborn babies'. This was the *Winterton Report*

[42], and the government's response, *Changing Childbirth* [43], recommended more involvement of midwives, development of their roles and greater patient choice over the professional providing care and where to deliver it. So far the government was very focused on mortality rates, but it stressed that the first principle of the maternity service should be 'woman centred'. Policy and professional position papers from the RCM reinforced this association between midwife-led care and WCC.

Fahy [44] wrote an editorial on the definition of WCC in which she argued that midwifery is a discipline that supports the relationship 'with the woman' and that maternity services should support this women-centred midwifery care by providing continuity of relationship during pregnancy and labour. Then, Berg et al. [45] looked at the definition of midwifery care concepts for Sweden and Iceland in the recent literature to identify a midwifery model of WCC that would best fit their context. Their results, as the most current statement about the midwifery care model, addressed that the new midwifery model was similar to the midwifery care model described by the International Confederation of Midwives which gives a focus on normality during pregnancy.

Several projects in Australia and the UK have addressed the importance and the effectiveness of providing WCC for low risk with midwife-led care and high-risk women in collaboration with obstetricians and other HCPs [46, 47]. Leap [34] already addressed the tension that WCC is seen as exclusively linked to normal birth and midwifery-led care [24]. In most circumstances, a midwife would take the role of lead professional for all healthy women with straightforward pregnancies. Additionally, for women with complications, an obstetrician would be the lead professional, and the midwives will provide midwifery care in collaboration with other professionals [41]. The Cochrane review [40] compared midwife-led models of care to other models of care (e.g. obstetrician or family doctor or shared model of care) and suggested that women who received midwife-led models of care were less likely to experience intervention in comparison with women who received other models of care. The review included studies with women classified as both 'high and low' risk, with the exclusion of women currently experiencing both acute maternal complication and substance misuse. The authors note that the same results may not be applicable with women experiencing obstetrical complications and not being under midwife-led care. It is only recently that the RCOG have embraced this concept in their guidelines. In the revised position statement in 2008, the RCM stipulated that "truly WCC must encompass midwifery-led care of normal pregnancy, birth and the postnatal period and services that are planned and delivered close to women and the communities in which they live or work." ([37], p. 2). This statement highlights WCC as including uncomplicated pregnancy, with midwife-led care being provided in midwife-led settings such as home, freestanding and alongside hospital birth centres for women defined as having a low clinical risk.

Finally, the key concepts of quality in maternal and newborn care presented in the Lancet Midwifery [48] included: safe, effective, accessible, appropriate, affordable, equitable, efficient, and woman-centred care. This framework for maternal and newborn care referenced the WHO Quality of Care report [49] as the primary reference, but they use the term patient-centred care not women-centred care, which highlights one example of the terms PCC and

WCC not being used consistently. This may be due to a lack of clarity about their dimensions and in which context one should be used and not in the other. The results of this study have highlighted the gaps in WCC as needing to be more inclusive of women, regardless of risk or model of care. Until there is more consistency and acceptance about WCC for all women, regardless of model of care, it may be that, as this study suggests that PCC may be a more inclusive model.

More recently, contemporary policy documents have alluded to WCC being for all women—not just those receiving midwife-led care [50, 51]. If WCC is to apply to all women using maternity services, then it would be beneficial to reflect this in its definition. For example, specifying that WCC is for all women, regardless of risk, pathway of care or lead healthcare professional. This would be more inclusive and support maternity services to apply this concept more broadly, enabling all women to benefit from this philosophy of care.

Identifying the most appropriate model of care for maternity services with a clear definition of each domain would help governments and professionals to develop goals and implementation strategies to improve the quality of care delivered. The review of other models used in maternity service policies shows that family-centred care places an emphasis on the sick child [52, 53] and person-centred care relates mainly to elderly people or those with long-term health conditions [54, 55]. Thus, these last two terms do not match the state of health and age of women in their reproductive life using maternity services [56]. Therefore, an alternative model of care is necessary for women who present various status of health when being pregnant. PCC has also been used in maternity service policies and offers such an alternative [57–59].

### **3. Reflection on Shaller's PCC model and redefinition [60]**

PCC has been recommended as a marker of quality in health service delivery [61]. There are numerous definitions of PCC, but one of the most influential models that formed the foundation of the PCC approach was developed by Gerteis et al. [62] for the Picker Institute and incorporates seven key domains: (1) respect for patient values, preferences and expressed needs; (2) coordination and integration of care; (3) information, communication and education; (4) physical comfort; (5) emotional support and alleviation of fear and anxiety; (6) involvement of family and friends; and (7) transition and continuity.

Whereas other models may not be inclusive of the diversity of care that women may need, the 'coordination and integration of care' domain of the PCC model encompasses various care pathways that can fit with the uncertainty of childbirth. Of note, this domain is not dependent on the HCP function and incorporates the variety of healthcare professionals that some women may encounter, including the dynamic nature of risk within pregnancy. This has the advantage to allow women to easily transit from one pathway of care to another without any effect on their model of care. Finally, the PCC 'respect for patient values, preferences and expressed needs' domain is comprehensive enough to consider the general and specific issues of women's needs and expectations when using maternity services. When one of the most

referenced definitions of PCC is reviewed, it appears that PCC may be a more appropriate model of care for maternity services, as per described; see [63]. Shaller's [60] framework of PCC described a brief outline of the six domains including:

- Domain 1: Education and shared knowledge
- Domain 2: Involvement of family and friends
- Domain 3: Collaboration and team management
- Domain 4: Sensitivity to non-medical and spiritual dimensions
- Domain 5: Respect for patient need and preferences
- Domain 6: Free-flow and accessibility of information

A comparison of the data collected in the multiple case study approach about maternity services with the existing literature highlighted further elements in each one of the domains. A revised model could integrate a stronger appreciation of the importance to provide individualised information by their care provider (d1), highlighting the opportunity for a greater involvement of the family and friends (d2), with a continuity of care (d3), an awareness of anxiety in any pregnancies and the midwife as the person to refer to in this situation (d4), and the development of clear and achievable expectations (d5), using multiple interventions that support communication. A revised model of PCC presented below is inspired by the Shaller definitions (plain text) and includes additional or alternative terms about the domains. This revised model provides more details and uses semantics that are generalisable to other services not just for maternity services but also for other health areas.

#### 4. Proposed revised model of PCC

**Domain 1:** Timely, complete (generic and individual), evidence-based information that would be delivered by experts in the field (ideally their care provider). This information should reflect the diverse opportunities made available to women by the institution to be involved in care delivery (antenatal consultation, antenatal classes, hand-held records, diaries, private consultations, etc.).

**Domain 2:** Involvement of partner and family in decision-making as an advocate of the woman when needed and with an awareness and accommodation of their needs as caregivers with an evaluation of their experience as service users.

**Domain 3:** Continuity of care between the diverse HCPs and the person receiving the care, with the inclusion of their partner and family during physiological and complicated care.

**Domain 4:** Incorporating emotional support, spirituality and attention to non-pharmaceutical treatments (e.g. human touch, massage, etc.), with an awareness of quality of life.

**Domain 5:** Respect of patient's needs, preferences, beliefs and values. Supporting people to develop achievable aims and to know also what they can expect from the institution.

**Domain 6:** Informing and empowering patients through consumer-oriented health libraries and patient education. Healthcare practitioners communicate and share complete and unbiased information with patients and families using diverse strategies freely accessible outside the hospital and out-of-normal hours.

## 5. Relating the revised model to existing literature

The proposed revised definitions of PCC are close to the person-centred care definition published by the Scottish government in the Healthcare Quality Strategy for NHS Scotland (2010) and so beyond the disease-oriented definition, including shared decision-making and mutual partnership with the person and their families.

It became apparent that policies were shifting their terminology from PCC in those reviewed after 2009 [64–70] to person-centred care in the last policy analysed [71]. Over the past 5 years, the model of person centredness has increasingly appeared in UK health policy and, more specifically, in Scotland in the past 5 years. Today, person-centred care is also central to the four UK countries, i.e. Vision 2020 for Scotland [72], the Health and Social Care Act [73], Department of Health Northern Ireland [74], and the Welsh White Paper [75]. Whereas prior PCC definitions focused on the pathology [2, 76] and the person-centred model on oncological and gerontological care [55, 77], the recent definitions of person-centred care by the Health Foundation [54] have tried to include principles, rather than a definition, for example:

‘(1) Affording people dignity, compassion and respect. (2) Offering coordinated care, support or treatment. (3) Offering personalised care, support or treatment. (4) Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life’ ([54], p. 6).

The Health Foundation proposed four principles of person-centred care rather than definitions as they can be restrictive. Unfortunately, it omitted to explain how each one of the principles could be delivered in practice, which can be more easily evaluated and improved upon than proposing broad approaches that are not clearly linked to one principle. The levels of the principles do not yet provide the level of details that Shaller’s model proposes, which supports a clearer implementation and evaluation process. Through this research the Shaller’s model has been demonstrated to be appropriate for maternity services as it offers a model of care that includes a continuum from wellness to illness for women who present in various states of health during the course of their pregnancy. The similarities of the themes used between PCC and person-centred care (e.g. respect, support and positive reinforcement) and between PCC and WCC (e.g. individual needs (emotional, physical, psychological, spiritual), choice, continuity and decision) provide evidence of PCC’s relevance and potential. The research also demonstrates how this could be further improved.

A clear definition of the model of care is essential for policymakers and practitioners to improve the system in place. Giving a definition of the PCC model in the policy will help the implementation of the intervention and set the scene for its evaluation and the further revision of the policy and the model itself [78]. Clarity and transparency of the model of care

chosen and its accompanying definition will benefit its implementation along the whole pathway [79]. To date, Shaller's theoretical framework appears to be the most inclusive model and remains the representation of PCC reported at global level. The domains have also recently been used in describing person-centred care [80–83]. It could be because its definitions and key factors for achieving PCC are the most representative to complex health systems, with the acknowledgement that no other theoretical framework has been able to address both the diversity of women's clinical conditions and HCPs' provision of roles.

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