EASTERN HEALTH BOARD

Consumer Satisfaction with Maternity Services

A study in a Dublin maternity hospital

by

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CONTENTS

PREFACE

During the last few years, there has been considerable public interest in maternity care in Ireland. A number of organisations have been formed which include consumers of maternity care. Some of these organizations have pressed for changes in the maternity services. There has been a demand for more services for home delivery, and indeed a court case dealing with this question has taken place. As a result, the maternity services have received considerable attention from the media.

On the assumption that demand for change may reflect a certain amount of dissatisfaction on the part of the consumers with the existing situation, it was decided to carry out this study of consumers' views of maternity services. It is hoped that such a study will provide useful information for those involved in the planning and administration of the services, and that it will ultimately lead to a better service for the users.

INTRODUCTION

There have been major changes in maternity care in Ireland over the past quarter of a century. Whereas in 1961, 20% of births occurred at home, by the end of the 1970's this figure had fallen to less than 0.5%. Many small maternity units have closed during this period, and the percentage of births occurring in units delivering over 2,000 babies per year had risen from 30% in 1966 to 72% in 1980 (1). This change from domiciliary to hospital care has been associated with a large investment in technology so that obstetrics has become an increasingly technical speciality. Mothers are giving birth at an earlier age and having fewer children than in the early 1960's. These changes and developments have been associated with a fall in maternal deaths from one death per 2,200 live births in 1961 to less than one death per 7,000 live births in 1979. Perinatal mortality has fallen from one death in every 28 births in 1961 to one in every 57 births in 1978 (1).

The extent to which each of the various factors mentioned above contribute to the improved chances of survival of mothers and their babies is by no means clear, and the increasing institutionalization of childbirth is viewed by some people as a mixed blessing. The concept of consumerism in medicine has lead to growing numbers of consumer assessment studies of medical care in Britain and the United States, but there has been little work in this field in Ireland as

yet. It, therefore, seemed timely to apply some of the methods developed elsewhere to a consumer study of maternity care in Ireland, especially in view of the increased public interest in this area.

The study was undertaken in order to obtain an assessment of patient satisfaction with maternity care as provided through an Irish maternity hospital. This was done using an interviewer administered questionnaire. More specifically the study objectives were as follows:

1. Antenatal care

   (a) To determine how satisfied mothers are with antenatal care, particularly in relation to doctor-patient communication.

   (b) To obtain some information on the reasons for any dissatisfaction found to exist.

   (c) To examine the relationship between some maternal characteristics and levels of satisfaction with antenatal care.

   (d) For those having combined general practitioner-hospital antenatal care, to determine which type of care was preferred.

2. Labour and delivery

   (a) To determine how satisfied patients felt about care received from hospital staff during labour and delivery, and to identify reasons for dissatisfaction.

   (b) To obtain some idea of the extent to which various procedures used during labour and delivery were explained to patients.

3. Postnatal care

   (a) To determine how satisfied patients felt with care received from hospital staff during their stay on the postnatal wards, and to identify reasons for dissatisfaction.

4. To obtain some information about mothers' preferences for home births, midwife clinics, male versus female doctors and early discharge from hospital.

SYNOPSIS

Demand for change and public interest in maternity services in Ireland provided the idea for this study. The aim was to determine how satisfied mothers were with existing services, and to identify reasons for dissatisfaction.

Using a structured questionnaire a systematic sample of 150 postnatal mothers was interviewed at a large Dublin maternity hospital. Antenatal care was the main area of dissatisfaction, a quarter of the respondents being dissatisfied to some degree. Public patients were significantly more dissatisfied than private ones with antenatal care. The main problems seemed to be long waiting periods, too little time with the doctor and lack of information. Less than half of the mothers who availed of combined antenatal care preferred the G.P. part of it.

Attendance of primigravidae at antenatal classes was good (81%) and most who attended found them helpful.

Satisfaction with nursing care during labour was very high, 90% of mothers being satisfied. Satisfaction with pain relief and mothers' perceptions of degree of sympathy of nursing staff were both strongly associated with overall satisfaction with nursing care.

Nearly a quarter of patients reported that no doctor attended them during labour or delivey, but 86.4% of the remainder were satisfied with the attention received. As in the case of nurses, satisfaction was strongly associted with mothers feeling that the doctor was

sympathetic.

Ninety-six per cent of mothers were satisfied with nursing care on the postnatal wards, but 26% of mothers received conflicting advice, most commonly in relation to breast feeding. 83.3% of mothers were satisfied with care received on the wards from doctors but 22.2% of those who had caesarian sections were dissatisfied.

Willingness to return to the hospital for a future delivery was felt to be an index of satisfaction. Ninety-two per cent of mothers expressed themselves willing to return. Six per cent favoured home birth, but not because of dissatisfaction with their hospital treatment. None of these would be prepared to stay at home if that decision involved additional risk to their baby. Two per cent of mothers said that they would not return to the hospital because of the manner in which they had been treated on this occasion. All three had had emergency caesarian sections.

As a result of the study suggestions were made for starting midwife antenatal clinics, and paying greater attention to communication in the training of doctors. A plea was made for greater sensitivity in dealing with the patient who requires emergency section. The need for nurses to co-ordinate their approach to breast feeding was stressed.

SURVEY OF PREVIOUS WORK

Consumerism in medicine

There has been a massive expansion in technology in medicine in recent decades. The range and variety of procedures and equipment is immense in the medical field. However, this expansion has been associated with an enormous rise in costs, and because resources in every country in the world are finite the need to make choices based on sound evaluations of medical care has become apparent. There are five major approaches to the study of medical care (2).

Firstly, the structural approach considers the organization of medical institutions in terms of employee time use, client time use and smoothness of functioning. Usually the objective of such studies is to determine the best institutional structure without looking at measures of quality.

The second approach to medical care evaluation is the process approach and as the name suggests it focuses on the actual process of care. The process approach to medical care suggests that quality includes simply those medical practices which are recognized and taught by the leaders of the medical profession at a given time in a given population setting.

The third approach, end-result measurement focuses on the end result of care rather than on the process. This approach is based on the assumption that given similar cases, better care should result in shorter periods of illness, less morbidity and pain and lower

mortality.

The fourth approach, known as the impact approach looks at the effect of medical care interventions on the community at large.

Finally, the newest approach to medical care evaluation is patient perception of care, and this is the approach with which we are concerned in this study. Some workers group this type of measurement with the process or end-result approaches, but this is not correct because an individual's perception of care is more complex than either of these. Patient's perceptions are affected by experience of previous medical care, the patient's mood during the interview, and the time of assessment (2).

It should be emphasized that a complete evaluation of care involves all five approaches because a good result using one approach does not necessarily mean the four other aspects of care would be equally good.

Traditionally patients have had a passive role in the health services. The concept of the patient as a consumer is relatively recent. However, this concept carries major implications for the relationship between the professionals and the public. To refer to someone as a consumer implies three things: an element of choice, the possession of information about alternatives and the possibility of refraining from buying. However, the hospital patient does not conform to the pattern of consumer in the economic text book sense. The scope of choice of the patient as a consumer is related to the nature of their illness, among other factors. Before patients assume the sick role they may have considerable choice, i.e. they can decide whether

to go to a chemist, a G.P. or a casualty department. Consumer choice is somewhat more limited in the area of optional surgery - for example tonsillectomy, cosmetic surgery or abortion. When medicine becomes a matter of life or death consumer choice stops - for example in the case of diabetic coma or severe road traffic injury. The doctor's responsibility is greatest and the patients' choice is smallest in the most money intensive parts of the health service.

However, the patients' medical condition is not the only constraint on their role as consumers - their economic and social status may also be important factors and there is evidence that higher social class and better education increase patients ability to make full use of available services (3).

The consumer movement in health care began in the United States in the 1960's but there are hints that it might be losing momentum by the 1980's. Increasingly business and industry and government are buying health services on behalf of the people. The increased power of buyers in terms of law, policy and economic control in the health care market-place suggests that the consumer movement may have diminished importance in the foreseeable future (4).

Some observers of the movement in Britain have expressed similar views. Industry and commerce have felt bold enough to argue publicly that the rules and regulations protecting consumer interests are increasing the costs of production and distribution to the detriment of the consumer himself (5).

Checkoway sums up the present situation in the United States as

follows:

> "In an area where providers had traditionally dominated planning without challenge, the very foundation of consumer groups might be viewed as a significant social change. For, whatever the fate of current health planning, the news is that some consumers are organizing for change. In an imbalanced political arena such as health care, whether in this round or another, this may yet be the most important political fact of all." (6)

Consumer surveys of medical care

One of the first major sudies of hospital care from the point of view of the patient was that published in 1964 by Cartwright (7). This involved a random sample of people in 12 constituencies in England and Wales who were asked wheher they had been hospitalized in the previous 6 months, and if so whether they would take part in the survey. Eighty-one per cent of these - 739 patients - were interviewed. The sample was reasonably representative of adults of all social classes in England and Wales.

Most patients were grateful for the way the nurses had looked after them, but one-third of the examples which they gave of nurses being unkind related to other patients rather than to themselves. Early wakening and frequent bedmaking were apt to irritate patients. On the question of privacy, two-thirds mentioned some disadvantage of being in a ward with other patients, but only 8% said they wanted a room of their own. However, small wards appeared to be more acceptable than large ones. Over half of the patients described some difficulty in getting information while in hospital. Cartwright argues that the problem of staff-patient communication is more difficult than hospital

staff appreciate, and that it requires more attention in the organization of hospital routines and in medical curricula. She goes on to say that while doctors are the most important source of information for patients, they tend to underestimate both patient's desire for information and their ability to understand explanations.

One-third of patients were critical of visiting arrangements, usually because they were too short or were at inconvenient times. As regards social class differences, middle class patients were more critical of nurses and of the information they received than working class patients. This may have been related to their higher expectations.

Cartwright concludes by saying that the criticisms need to be seen against a background of general satisfaction, but that public opinion could be a potent weapon for improvement of the health service provided it is based on knowledge of facts and informed criticism (7).

In a review article published in 1972 Ley suggests that the training of health service staff should emphasize the importance of discovering and remedying sources of patient and staff dissatisfaction (8). He draws a numer of conclusions from previous work about patient complaints. Firstly, patients frequently have complaints about various aspects of their hospital stay. Secondly, hospital staff are not necessarily good judges of the relative importance to patients of unsatisfactory aspects of hospitalization. Thirdly, patients are slow to voice complaints for various reasons - including lack of opportunity, not wanting to cause trouble and the belief that nothing

would be done. Fourthly, even when complaints are made, most patients do not feel they have been dealt with satisfactorily. Ley concludes that it is necessary to have some procedure for discovering unvoiced complaints, and that such a procedure should not discourage complaints. The objective of such a procedure should be to identify causes so that remedial action can be taken, but there should be a method of assessing the effectiveness of such remedial action. However, in relation to complaints in the important area of staff-patient communication he cautions that commonsense plausible remedial measures will not always be successful. He cites two possible reasons for failure of such measures - firstly patients do not always understand what is said to them and secondly they frequently forget what they are told. However, he concludes that surveys of patients both in and after discharge from hospital would be valuable (8).

Others are less keen on the idea of encouraging complaints from patients. There has been criticism of the U.K. Health Service Commission for expending a disproportionte amount of time and resources on investigating trivial and unreasonable complaints. It has been suggested that an open-ended complaints procedure that includes clinical judgement may be counterproductive in that it may discourage voluntary medical audit (9).

There have also been warnings about possible adverse effects of health services being more responsive to consumer demands and complaints. One perverse effect of this might be to weaken attempts to divert resources for services from the most vulnerable groups such as the elderly, the mentally ill and the handicapped - precisely those groups

who can neither exit into the private sector nor exercise voice in the political market (10).

In a study carried out in Vermont, New England in 1970, 336 patients discharged from a large training hospital during a seven week period were requested to respond to an interviewer administered questionnaire (11). Eighty-five per cent responded and were interviewed in their own homes. Ninety-eighty per cent stated that they had received the best possible medical care, but despite this 25% had been unable to find out all they wanted to know. Despite high levels of satisfaction with their physicians, 17% expressed themselves reluctant to return to the hospital in the event of a future illness. It was suggested that this reluctance to return was influenced by distance from home, annoyance with admission procedures or room environment. The authors made a number of pertinent observations at the end of their study, which could also apply to other consumer studies of medical care. First, the results are relative only; they are not absolute truth, nor do they confirm or deny the "goodness" of hospital practice. Secondly, they suggest that there is a limit to how much satisfaction can be obtained. For example, they ask is it acceptable that 7% of the patients still wished to ask more questions when they left the hospital? Thirdly, they ask how far do patient perceptions relate to reality? Finally, they note the "soft" nature of the data collected in consumer studies of medical care and comment that work of this type is an inexact science.

In 1969 Hulka et al conducted a household survey among low income people in North Carolina and collected data on utilization and satisfaction with medical services from 254 adult respondents. They

used a sophisticated questionnaire constructed in accordance with Thurstone's Equal Appearing Interval technique. They found increased levels of satisfaction with professional competence among the better educated and those in higher occupations. People with larger family size were less satisfied with costs and convenience. Possession of medical insurance, a regular doctor and having had a recent visit to a doctor were associated with higher satisfaction. Because variation in satisfaction scores occurred in the 'expected' direction, Hulka et al concluded that their research was reasonably valid (12).

Later work confirmed the reliability of this scale, but cast doubt on its validity in a community setting (13).

Using a self-administered questionnaire, a household survey of 432 adults in Springfield, Illinois (14) was carried out in 1974. The sample differed in some respects from the general population. Multivariate analysis was performed on the data collected. Physician conduct emerged as the most important factor related to general satisfaction for the total sample and for subgroups of different ages, sex, education and health status. Other important factors included continuity of care, accessibility and availability of family doctors. The authors concluded that satisfaction could be improved by improving physician conduct, especially by organized performance of clinical examinations, adequate explanations and a friendly manner. They also noted that scales to measure consumer perceptions of medical care are now sufficiently reliable to measure the differences between groups.

In a survey of 167 patients at a university hospital in South Carolina a specially developed multiple choice questionnaire was used. A

4-point satisfaction scale was used and a number of hospital services including admissions, nursing, doctors and radiology were evaluated. The average score out of 100 from the whole hospital was 84. All services were rated close to 90, suggesting a positive view of staff attitudes. Lower social class and black race were associated with higher scores. Patients staying in hospital for more than two weeks rated the hospital lower than those staying in for less than two weeks. Patients previously admitted to the hospital produced higher scores than those not admitted before. The authors speculate that this may be due to the fact that patients with more knowledge about the hospital perceive it in a more positive way. They do not consider the possibility that the patients who return to the hospital may be a self-selected group who had previously had a good experience there (15).

In 1969 Raphael published the results of a detailed survey on the views of patients in 10 general hospitals in the United Kingdom (16). The survey was repeated on 11,000 patients in 68 general hospitals in 1976 (17). There was evidence of an improvement in the later study. The major area of discontent was with toilet and washing facilities. Food appeared to have improved considerably in the interim. However, on the question of patients being given enough information on their illness and treatment, 14% felt they had not, a similiar finding to the first survey.

The relative effects of organization and individual attributes on consumer satisfaction with humaneness of service were examined in a survey of 417 staff members and 411 patients at 11 different health agencies in Wisconsin. Following regression analysis certain

organizational attributes were found to be associated with higher consumer satisfaction. These included absence of bureaucratic rigidity in staff procedures and good communications within the organization itself (18).

A study comparing patient satisfaction with training hospitals as aginst private hospitals in Chicago found that 15% of patients treated at teaching hospitals were dissatisfied with their stay as against 7% of those treated at non-teaching hospitals. This finding was contrary to the expected relationship. The author specuates that the training goals of teaching hospitals may lead to patterns of behaviour among hospital personnel that may offend some patients and be interpreted as poor quality care (19).

Consumer views of maternity care

> "The problem of combining the efficiency of the conveyor belt with individual attention in the presence of staff shortages can be found in most aspects of modern life. As far as the maternity services are concerned, its solution probably depends on recognizing the changes that have taken place in the last 25 years - economic, social, psychological and medical... Childbirth is becoming an important experience which can also, under suitable conditions, be enjoyable, and women are demanding that it be made so. Despite the difficulties, it is our responsibility to see that this becomes a reality and not a nightmare or a calamity." (20)

This passage is not a response to consumer demands for changes in the maternity services in the 1980's. It was published in the Lancet in 1961 and is included in order to illustrate the point that questionning of maternity services is not particularly new. In the United Kingdom there has been considerable interest and concern in the quality of maternity care both among the public and among doctors and nurses for over a quarter of a century. The Association for

Improvements in the Maternity Services was formed in 1960 (20). Its aim included an intent "to banish, through influence, the dark age attitude towards the psychology of childbirth and to eliminate all unnecessary suffering in childbirth."

The Cranbrook report was quite critical of hospital maternity services, but emphasized that the majority of women questioned by the committee appeared to be satisfied with the maternity services. This was in 1959. Areas of dissatisfaction included lack of attention to dignity and to the emotional side of childbirth in hospital, being left alone in labour, lack of analgesia and lack of privacy. Long visits at antenatal clinics and rigid hospital routines were also criticised (21).

In Cartwright's survey of hospital patients carried out in 1964 (7) 16% of the total sample of 739 were maternity patients. There were much higher levels of criticism of nursing care among this group than among general hospital patients. Being left alone in labour was a major factor in this respect. Sixty per cent of all mothers were left alone during labour, and this rose to 69% in the case of primiparae.

A more limited study carried out in 1969 in Florida found more positive attitudes to maternity care when it was delivered via a peripheral clinic. There was considerable criticism of the confusion found in the hospital antenatal clinic, and of the lack of information from doctors in hospital. The authors were under no illusins as to the representativeness of their sample as the response was only 38%, (22).

In a somewhat unscientific study carried out in 1970, the Consumer Association in Britain analysed 3,000 questionnaires filled out by its members who had delivered within the previous two years. They also interviewed a sample of 300 mothers, mainly from the lower income group. While most mothers in both groups were satisfied, there was a tendency for mothers attending G.Ps or private consultants to be more satisfied with antenatal care than those attending hospitals or local authority clinics. There was criticism of long delays, lack of privacy and conflicting advice from clinics. On the question of labour and delivery there was dissatisfaction over being left alone and with management of pain (23).

By the mid 1970'S considerable changes had occurred in obstetric practice in some Western countries. These included admission of husbands to labour wards, regional analgesia and a greater awareness on the part of obstetricians and midwives on different attitudes to labour among the general community.

In Sydney, 500 women were interviewed about some of these issues during their early postnatal period (24). Twenty per cent of mothers had no idea of what to expect in the labour ward. As regards analgesia, only 47% of those who used nitrous oxide felt it helped a lot, while 96% of those who had epidural analgesia had no regrets. At least half of all patients had severe pain at some stage of their labour but 88% felt that enough was done to relieve their pain. Ninety-seven per cent of those women whose husbands were present during labour considered his presence helpful. There was widespread acceptance of the presence of medical students in the labour ward

during delivery. Three per cent complained of lack of company during labour. One important question involved the qunstion of attitude to a future labour. Thirty-nine per cent were unhappy about the idea because of their recent experience, particularly in relation to analgesia. The authors were well aware of the subjective, retrospective uncontrolled nature of the study. However, in the field of consumer satisfaction with medical care one is impressed by the broadly similar results obtained in relatively simple and crude studies such as this when compared with sophisticated elaborate research.

By the mid-1970's interest in the mothers' view of maternity service's was running quite high in the United Kingdom. Two important studies were carried out in 1975. Firstly Kirke's study in two London hospitals concentrated on staff-patient communication and on the management of labour (25) (26) (27). Secondly, Cartwright's major survey looked at the whole question of induction of labour (28).

Kirke personally interviewed 210 mothers during the postnatal period, while they were still in hospital. Half of the mothers mentioned some significant failure of communication, and satisfaction with communication was significantly associated with overall satisfaction with care. The author also interviewed 22 doctors about their usual practice in relation to explaining procedures to patients. The proportion who stated that they usually gave explanations was very high - over 90% for most procedures. Kirke speculates that doctors were not giving explanations to the extent they believed in view of the large proportion of mothers who mentioned some failure of communication (26).

Kirke also studied mothers' views of the management of labour. Willingness to return to the hospital in the event of a future pregnancy was used as an indication of overall satisfaction, and 77% of mothers said they would return. Overall satisfaction was associated with the manner in which care was given by doctors and nurses during labour, and with not being left alone in labour. Thirteen per cent of the mothers claimed that no doctor attended them during labour and 43% said they had been left alone for at least 5 minutes. Mothers were generally favourable about such procedures as induction, intravenous infusion and continuous fetal monitoring, but were not very impressed with the effectiveness of epidural analgesia. Overall satisfaction was not related to the personal characteristics of the mothers themselves (27).

Cartwright's major survey of 1975 involved a sample of 2,400 mothers in 24 randomly selected areas of England and Wales (28). Ninety-one per cent were successfully interviewed, most within 5 months of delivery, using a large structured questionnaire. The main purpose was to find out the views of mothers on induced as against spontaneous labour. The great majority of women did not want induction in the event of their having another baby. Among those with experience of induction, over 75% would prefer not to be induced. The main reason for the objection to induction was that it was felt to be unnatural. Other findings of note included the facts that nearly two-thirds of mothers were unable to hold their babies immediately after birth and 75% were unable to feed their babies when they wished, but had to conform instead to a fixed routine. Eighty per cent of mothers wished to be involved in the decision-making process but only 33% of

those induced felt they had had a choice.

In a carefully designed study comparing levels of satisfaction with obstetric care between Australian-born and Greek migrant women in Melbourne, 35% of the former were critical of their care as against 26% of the migrants, using a specially constructed index of overall satisfaction. The different levels of criticism concerned mainly the doctor-patient relationship and organizational aspects of hospital care. Better educated respondents were more critical than the less well educated. Mothers with greater health knowledge and those whose self-assessed health status was worse during pregnancy were less satisfied, as were mothers with more obstetric complications. There was little difference in satisfaction between those who had private care and those who had public care.

The authors speculate that factors such as different levels of sexual role fulfillment and differences in expecttions may explain some of the difference in satisfaction between Australian-born and Greek migrant women (29).

The authors, who appear to have given the whole question of consumer studies of satisfaction with medical care more thought than many other workers point out that if satisfaction with care is to be used as an index of quality of care in future studies, a number of theoretical and methodological issues have to be faced. These include identification of factors which though not associated with the events of care have an impact on satisfaction. In theory, at least, it should then be possible to study directly the effects of quality of care on satisfaction with care after controlling for effects of all

these factors. The end-stage of this analysis will involve the interpretation of multivariate statistical tests which may not be straightforward (29).

In a mainly black private obstetric practice in Chicago, one quarter of 265 patients who filled out a self-administered questionnaire were dissatisfied with the services provided by their physicians. Some of this dissatisfaction was associated with not seeing the same doctor at every visit. Half the patients felt they had been kept waiting for unnecessarily long periods to be seen by the doctor. This complaint was commoner in younger women (30).

In another study using a self-administered questionnaire among a sample of 368 women at a Nottingham maternity unit, most women were satisfied with their length of stay, their accommodation and dressing arrangements. Sixty-two per cent would have liked to be free to walk in the hospital grounds. Lack of sleep and complaints about food were common. Sixty per cent complained about early waking (5.30 a.m.). Arrangements for visiting by husbands gave rise to considerable complaints and 70% of the sample would have liked open visiting for their husbands. Conflicting advice was a considerable problem - at least 25% of the sample complained of this. The authors make a number of commonsense recommendations about postnatal care as a result of their study (31).

By the end of the 1970's a flood of articles in the popular women's press suggested that there may be widespread uneasiness with the birth process in the United States. In an attempt to determine the degree to which this was true, the Arizona Department of Health Services

conducted a self-administered questionnaire survey of all resident women to whom a birth certificate had been issued during a one month period in 1978 (32). There was a 52% response out of 3,773 questionnaires mailed. Teenagers and women in lower socio-economic groups were underrepresented among respondents. Three per cent of respondents delivered outside a hospital. Ninety-three per cent of respondents were satisfied or very satisfied with their care. As regards staff-patient communication during antenatal care there was an association between time spent discussing problems and empathy shown by the caretaker with satisfaction. There was also a strong association between perception of care in labour and delivery and satisfaction with care, especially as regards communication. There was some evidence that women were reluctant to criticize caretakers as many of those offering highly negative comments on the questionnaire still ticked satisfied in response to the question evaluating overall labour and delivery care. The authors suggest that this paradoxical finding may be due partly to the joyful halo surrounding the birth of a healthy baby. Of the 20% of women who had planned home births most indicated greater rapport with their caretaker and greater control over the birth as their main reason for choosing home delivery rather than a previously negative hospital experience. There was a strong desire for childbirth courses, controlled breathing and relaxation in labour, although the majority of women also wanted analgesic medication during labour but did not wish to be rendered unconscious for delivery.

The authors conclude that the popular women's press does not accurately reflect the interests of the majority of women on some clinical procedures and a sizable minority of other issues. They

suggest that a more satisfactory course of care depends on more attention to interpersonal relationships between caretakers and patients and greater flexibility in clinical procedures (32).

A similar hypothesis was tested in a well-designed study of 1,000 mothers who delivered at Queen Charlotte's hospital in London in the early 1980's (33). Sixty-three per cent of the sample returned the questionnaire which was sent one year after childbirth. Eighty-five per cent of mothers disagreed with the statement that mothers should not have so much medical attention in labour, and 63% found fetal monitoring in labour reassuring. Only 16% agreed that home deliveries ought to be encouraged. Only 19% agreed that a mothers feelings towards her baby are affected by how she felt in labour and that a baby's personality is affected by the ease or difficulty with which it is born. None of these views were in close agreement with the "natural childbirth" school of thought and the authors conclude that some of the fashionable views on childbirth do not have wide support.

On the other hand not all views were in line with the "established medical view" either. Forty-five per cent of respondents thought that pain was a necessary part of the emotional experience of childbirth, rejecting the medical view that pain is an unnecessary and unwanted aspect of labour that ought to be relieved as completely as possible. Only 50% considered epidural block to be the best form of analgesia in labour and 61% agreed that having a sympathetic midwife to help mothers throughout labour is more important than all treatment for pain relief. The authors conclude that some of the most time-honoured views held by the medical establishment are not

supported by many mothers. They suggest that the attitudes of their large representative sample of mothers should carry more weight than the opinions of the vocal minority which are frequently quoted in the media, but that more attention to the emotional aspects of childbirth might reduce the dissatisfaction which feeds extreme views (33).

The Irish Scene

The literature avilable on consumerism in Irish obstetrics is fairly scanty. One study published in 1978 looked at the reasons why women pick a particular one of the four large maternity units in Dublin (34). Seventy patients were interviewed in each of the four hospitals. Patients in private rooms were excluded. Family and friends were the main factor influencing choice of unit in 90% of cases. General practitioners also had a considerable influence on women's choice but the media played little part. Many couples wanted their babies to be born in the same hospital in which they themselves were born. Safety considerations were cited as the main reason for choosing hospital delivery instead of delivery at an alternative location.

A survey of the public's image of the doctor was carried out in a random sample of people from eight electoral wards in Dublin. Results suggested that the public has a very positive image of the doctor. Younger people were more critical as were those in the lower social classes. A small group of 1 - 2 % had a very negative view of the medical profession (35).

The midwives' section of the Irish Nurses Organization carried out a survey of 1,600 mothers during a two week period in 1980 (36). A

self-administered questionnaire was used and the objective was to discover how pregnant women viewed maternity care. There was a 78% response. As regards waiting, 12% of patients waited over two hours and 19% experienced some difficulties regarding clinic attendance. In 16% of cases the doctor explained things to the patient without her having to ask questions. Thirty-four per cent of respondents had received antenatal care from a different person each time. Thirty-one per cent felt privacy in the antenatal clinic was insufficient.

As regards care during labour and delivery it was stated that clients generally considered it reasonably satisfactory. On the question of analgesia, of those who had an injection, 74% considered it very effective whereas the figures for inhalation analgesia and epidural were 93% and 75% respectively. Seventeen per cent felt they were left alone for too long during labour. Twenty-three per cent did not hold their babies immediately after birth. Mothers were asked what changes they felt would be desirable in the structure and organization of the labour ward. Four per cent considered a single room desirable. Six per cent considered music desirable. Two per cent considered the opportunity to walk around desirable. Early waking and lack of education in relation to feeding and baby care seemed to be the major problems in the postnatal wards. Unfortunately the details of the methods used in the study are not clear, and thus it is difficult to judge its true value (36).

In a psychological study of mother's experiences of childbirth in Co. Cork, 35 mothers who delivered in hospital and 10 who delivered at home were interviewed. The author concluded that a number of

variables were associated with a positive feeling about childbirth in the mother. These included familiarity with the environment in which the birth occurred, knowledge of the process of birth and of the intervention procedures used and presence of husbands or other familiar people. Another hypothesis which was tested was that the greater the amount of aggressive obstetrics used the less likely the mother is to have a positive birth experience. No significant relationship between the two factors was found (37).

A Department of Health Committee carried out a major survey of the Maternity and Infant Scheme in 1980 (38). This scheme was introduced in 1954 and provides a service for medical attendance by G.P.s for maternity cases and infants up to the age of six weeks. Entitlement extends to women who are in Health Eligibility Categories I and II. Category I broadly represents the lower income group and Category II the middle income group. These two categories cover 85% of the population. The scheme provides for free antenatal care, attendance at confinement if necessary and postnatal care by any G.P. of the woman's choice who is willing to accept her as a patient. Ninety-three per cent of mothers delivering in Ireland in the last week of November 1980 were interviewed by public health nurses. This resulted in 1,188 completed questionnaires. The objective of the survey was to fill information gaps in relation to the Maternity and Infant Scheme. Only certain results of the survey are of interest from the point of view of consumer satisfaction with the service. Thirty-four percent of mothers eligible to use the scheme chose not to avail of it. When asked why not, 43% were under the impression that they were using it even though they had no G.P. care. Sixteen per cent preferred private obstetric care. Eleven per cent had Voluntary

Health Insurance cover. Five per cent said antenatal visits under the scheme took too long. Ten per cent said they did not know about the scheme. Six per cent said they wanted to get better care elsewhere and 9% gave no reason. Of the 68% of eligible mothers who did use the scheme 49% gave financial considerations as their main reason for so doing, whereas 30% used it because they were entitled to do so and 11% used it because they felt care was satisfactory. The average time spent away from home by all mothers surveyed was 3.2 hours for a hospital visit and 1.5 hours for a G.P. visit. When women who had combined G.P./hospital care were asked which they preferred 35% preferred the G.P., 19% the hospital and 42% had no preference (38).

From this brief review of the Irish literature it may be seen that information on the consumer's view of maternity care in Ireland is quite scanty. In view of the volume of discussion on this topic in the media and the amount of public interest generally a carefully planned study seemed appropriate at this time.

Doctor-patient communication

Many doctors and health care workers give problems of communication low priority in comparison to the more technical side of patient management. Up to 65% of patients in some surveys expressed dissatisfaction with doctor-patient communication, although the average figure in most series is about 30% (8). Some feel there is little point in doctors making special efforts to communicate as there are some patients who, because of peculiarities of personality, will be ungrateful and dissatisfied. However, there is not much to support

this as there is little evidence that satisfied and dissatisfied patients differ significantly as regards personality (39).

There is good evidence that patients want to know as much as possible. For example 75% of patients in Cartwright's survey wanted to know as much as possible about their illness (7). Compliance with medical advice has been found to be very low in some studies. Thirty to fifty per cent of patients in various studies have not complied with medical advice, and a direct relationship has been found between level of satisfaction and compliance (39).

The cognitive hypothesis suggests tht many failures of communication are due to patients not understanding and remembering what they are told. One study found that out-patients forget about one-third of what was said to them (40). They retained proportionately less of the information the more they were told. The younger patients (age 15 - 35) remembered least. Patients with an average level of anxiety remembered more than those with a higher or lower level. Recall was also related to the nature of the information given. fifty-six per cent of instructions were forgotten, whereas, only 28% of other information was forgotten. Thus, it is concluded that for communication to be effective patients must not only understand what is said to them, but they must also memorise it.

On the question of patients not understanding what they are told, three factors are thought to be involved (39). These are (i) the material presented to patients is too difficult (ii) patients often lack knowledge and (iii) patients are very diffident. This latter point emerged in Cartwright's survey where only 45% of the patients

said they asked for information. Social distance between doctors and patients contributed to this diffidence (7).

A study in New York looked at aspects of doctor-patient communication among 214 medical clinic patients. Although patients were found to be poorly informed about their own condition when they came to the clinic, and about 10 common diseases, physicians nevertheless underestimated their level of knowledge. Most patients seemed to have a latent rather than overt desire for more information. Few patients were given systematic explanations about aetiology, tests, treatment or prognosis, but those who were given more thorough explanations appeared more likely to accept the doctors diagnosis and plans for treatment (41).

Another study in Utah found that patients are more satisfied with their physicians when they are given and retain more information about their illness. It was found that the percentage of information retained by the patient was of equal importance in its effect on patient satisfaction, although satisfaction was not related to educational level or sex of the patient. In an experiment designed to increase retention of information by asking patients to restate what they had been told and repeating what they had forgotten to them it was found that retention of information increased from 61% to 84% (42).

Similar findings emerged in another study in Utah in which overall patient satisfaction with care was best predicted using four variables - satisfaction with outcome of care, continuity of care, expectations and doctor-patient communication (43).

Thus, there is evidence that failure of memory and comprehension may contribute to dissatisfaction of patients with communication and lack of compliance with advice. It has been found that by seeing that patients understand what they are told it is possible to virtually double the percentage of patients who are satisfied with communication (39). It is no longer reasonable to claim that concern with the communication's side of health care is merely an optional extra.

METHODS

Following perusal of the relevant literature and discussion with experts in the field of consumer studies in medical care, it was decided that the best way of achieving the study objectives was via a structured interviewer-administered questionnaire applied to women who had recently given birth.

The Study population

The target population was recently delivered mothers. It was decided that a systematic sample of mothers would be drawn from those delivering at one of Dublin's major maternity units. Although such a sample may seem at first sight to be poorly representative of the general population it is a fact that not more than 0.4% of deliveries now occur outside hospital (1). Secondly, the unit chosen was the one with a client group which most closely resembled the general population as regards age, parity, health service eligibility status and illegitimacy rate. This hospital was the Coombe Lying-in Hospital, Dolphin's Barn, Dublin.

Place of interview

The interviews took place in the postnatal wards of the hospital. Patients were interviewed in private, either in an empty ward sitting-room, in a vacant single room, or in the case of private patients, in their own rooms.

Timing of interview

It was decided to carry out the interviews on the third or fourth day after delivery. This would give the mothers time to get over the exhaustion of labour and delivery and to become acquainted with the ward staff and ward routine. At the same time the memory of their experiences would still be fresh in their minds. The normal length of stay in the Coombe hospital was 6 days for primiparae and 5 days for multiparae. Thus carrying out interviews on the third or fourth day post delivery enabled all interviews to be done before discharge.

Sampling technique

The survey was descriptive in nature and it was decided to use a systematic method of sampling. An excellent sampling frame was available in the form of the hospital birth register. All deliveries occurring in the hospital's two delivery suites are recorded in sequence in this register. Following pilot work which will be described later, it was decided to choose every second mother delivering at the hospital. The register was examined every evening following the day's interviews and the list for the following day was made out from the mothers' delivered three days previously.

Sample size

Following pilot work it was found that the maximum number of interviews feasible in one day was approximately 11. Each interview took approximately 40 minutes, and when allowance was made for ward rounds, breast-feeding classes, physiotherapy, meal times and visiting times it was found that it was virtually impossible to exceed 11 interviews per day. The average number of deliveries per day was approximately 19. This would yield about 9 per day if every second mother was chosen. It was decided to aim for a sample size of 150. This meant that the field work could be carried out in approximately 3 weeks, providing interviewing took place every day of the week, including weekends and bank holidays. As the usefulness of a sample increases in proportion to the square root of its size there seemed little to be gained by exceeding a figure of 150, unless a much larger number was feasible.

Exclusions

Because of the limited size of sample, it was decided to choose as homogenous a group as possible, in order to avoid skewing of the results. Thus unmarried mothers and those whose babies had major congenital malformations or were stillborn were excluded. It was also felt that it was inappropriate to interview such mothers at a time of severe distress, and that each of the above categories would be more properly studied in a separate survey. Twin deliveries were also excluded because of potential difficulties with coding and analysis.

Questionnaire development

The number of the studies of consumer satisfaction with obstetric care is fairly limited but copies of the questionnaires used by Cartwright (44) and Kirke (25) were obtained at the outset of this study, and these provided a useful basis for the development of a new and a somewhat more concise instrument. Many different factors were considered in its development. These factors have been discussed by Oppenheim (45) and Bennett and Ritchie (46).

The instrument developed consisted of four main sections. (See Appendix 1). These were concerned with antenatal care, care in labour and delivery, postnatal care and the final section dealt with miscellaneous items such as conflicting advice, midwife clinics, preoference for male or female doctors, the question of home births and lengths of stay. The majority of questions relating to personal deta ils were relegated to the end of the questionnaire in order to gain the trust and confidence of the respondent, as advised by Bennett and Ritchie (46). However, the sequence of the remainder of questions was as logical as possible, starting with early antenatal care and continuing through to the question of willingness to return to the hospital in the event of another pregnancy.

The possibility of using a self administered questionnaire was considered, as it would have enabled a larger sample to be studied, but the greater flexibility and the ability to probe and to motivate the patient towards completing the questionnaire outweighed other considerations. Also question sequence could be relatively simple without the need for a complex branching or filtering system. In the

antenatal section, questions relating to aspects of doctor-patient communication were asked twice if the mother had had combined antenatal care, whereas the second question was omitted if they attended hospital only.

Considerable thought was given to the choice between open and closed questions. Open questions require the respondent to recall something whereas closed questions require them to recognize something. Research suggests that more information will be recognized than recalled. However, there are some doubts as to the accuracy of the additional information gained by using closed questions only. On the other hand the coding and statistical analysis of closed pre-coded questions is much simpler (46). Locker and Dunt discuss this point in their review of methodological issues in sociological studies of consumer satisfaction with medical care (47). They suggest that direct questions function as probes to elicit dissatisfaction with aspects of care which have less impact on the respondent than those mentioned in response to open-ended questions. They recommend that a comprehensive measure of consumer opinion should combine both types of question. For this reason the direct questions on satisfaction with antenatal care, with labour and delivery and with postnatal care were placed at the end of the relevant section and were immediately preceded by two open questions. The first enquired about aspects of care found to be particularly good, and the second about things which were felt to be bad.

Consideration was given to question length. It was not always possible to limit all questions to a maximum of twenty words, as recommended by some (45), but the more realistic concept of limiting

the number of ideas contained within a question to one idea was adhered to closely (46). Every attempt was made to keep wording as simple as possible while attempting to avoid loss of precision.

Another point concerned measurement of the extent of satisfaction - dissatisfaction. While a simple dichotomy between satisfaction and dissatisfaction forces patients to choose one or other, a multi-dimensional scale gives some idea of the relative intensity of satisfaction and dissatisfaction and is a more sensitive instrument (47). However, the likelihood of having to collapse a multidimensional scale in order to obtain sufficient numbers for analysis in a relatively small study counteracted the advantage of sensitivity. Following a pilot study with simple dichotomous questions on satisfaction it emerged that many mothers had difficulty in placing themselves in either the satisfied or dissatisfied category. Some were generally happy with certain aspects of care but had definite complaints also.

Thus a third category "satisfied with reservations" was suggested. The majority felt this suited their situation exactly and thus this third category of satisfaction was introduced into the Final questionnaire between satisfied and dissatisfied. Considerable judgement is required in devising such a scale. Bennett and Ritchie state that there is no right answer to the problem of how many categories to include on a rating scale. It will vary according to the subject matter of the scale and the differentiation required (46).

Every step in the construction of a questionnaire may introduce bias and great efforts were made to avoid leading questions or loaded

words. The use of open questions prior to the direct questions on satisfaction was intended to identify possible halo-effects. It was hoped that the use of non-dichotomous questions would lessen the danger of response sets being obtained (46).

Validity refers to the efficiency with which a measuring instrument measures what it is intended to measure. It was a relatively simple matter to check the answers to factual questions against information in the birth register, for example, on items such as age of mother, sex of baby, induction, monitoring, mode of delivery, analgesia, date of delivery etc. However, validation of items involving opinions is extremely difficult. To some extent certain logical consistency checks were built into the questionnaire. For example if a mother replied unfavourably to several of the questions on doctor-patient communication during the antenatal check-ups it would be somewhat surprising if she expressed herself satisfied with antenatal care without reservation. However, the major problem in checking the validity of opinion and attitude questions is the absence of external yard sticks. There are no easy answers to this. One possible approach, although a costly and slow one would be to monitor the extent to which mothers returned to a particular maternity unit for subsequent births, given roughly similar accessibility of different units. There may be some value in this idea as a previous study showed that 9 to 10% of multiparous mothers gave a bad experience elsewhere on a previous occasion as their reason for choosing a different Dublin maternity unit (34).

Repeatability refers to the extent to which a questionnaire provides the same results on the same subject on two or more occasions.

Unfortunately, time did not allow more than one interview with each respondent, but some reassurance was gained from the fact that Kirke had found quite high levels of repeatability using a similar questionnaire in his study of the consumer's view of obstetric care in two London hospitals (25).

Organization of survey

The maternity unit chosen for this study, the Coombe, opened its doors on 17th July 1826. Its establishment followed the tragic death of a woman in labour in the snow in Thomas St., while on her way to the Rotunda. The move to the new site in Cork St. occurred in 1967 (48). The maximum number of women delivered there in one year was 8,385 in 1979. This had dropped to 7,153 in 1983, the year prior to that in which the present study was carried out (49). As noted above, the main reason for choosing this unit was the fact that its clientele appeared to represent the general population more closely than that of any of the other major maternity unit in Dublin.

The Master of the Coombe was approached and the nature of the study was outlined to him. He was given a copy of the proposed questionnaire and asked to comment on it. He expressed considerable interest in the survey and was quite pleased to have it carried out in his hospital. He felt it was important that any deficiencies found to exist should be overcome. He agreed that the details of the study should not be discussed with any other staff members until the survey was complete in order to avoid the risk of change in staff attitudes and behaviour which might ensue if the full details of the study were publicised in advance. He agreed to send a circular to all relevant

departments informing staff that the author would be carrying out a survey on maternity services and requesting their cooperation when necessary. During the study, discussion with staff was kept to a minimum.

Certain background information on the organization of services in the Coombe hospital is useful at this point. Patients are registered as "booked" if seen once at the antenatal clinic other than the occasion on which they are admitted. This includes patients seen by the consultant staff in their consulting rooms. Patients may choose to attend as public patients in which case they may attend the antenatal clinic at the hospital itself or alternatively one of the 3 peripheral clinics in County Dublin or County Meath, which are located in health board premises but staffed by a team from the Coombe. If they decide to attend semi-privately the majority of their antenatal supervision is done by an assistant master or registrar. Finally, they may choose to attend a consultant privately. There is also a combined antenatal care scheme in operation. Patients who choose this are seen at the hospital for their first visit, but the majority of subsequent check-ups until the latter part of the third trimester are done by the patient's own general practitioner unless a serious problem develops.

As regards labour and delivery, the induction rate at the Coombe is relatively high - 24.9% in 1983 (49) - as against a rate of 13.4% at the National Maternity Hospital, Holles st (50) and 10.6% at the Rotunda (51). Labour is actively managed and the caeserian rate is 7.6% with a forceps rate of 6.5% (49). Mothers may be delivered on a standard delivery couch or alternatively on the recently-introduced birthing chair.

Postnatal accommodation may be either public (6 bedded wards), semi-private (also 6 bedded) or private (single room). At the time of writing, the normal length of stay for primiparae was 6 days and 5 days for multiparae.

Pilot studies

A pilot survey under full study conditions was undertaken in June 1984 in the Coombe. The sampling technique was found to work well as it was relatively simple to check the birth register each evening in order to make out a list of mothers for interview next day. Although mothers were interviewed on the fourth day after delivery, some were actually classified as third day because if a mother delivers after midday the following day is taken as Day 1. All mothers were numbered consecutively on the register from the beginning of the year. For sampling purposes, all mothers with an even number delivering on the appropriate day were included unless some exclusion criterion was present. If that was the case the subsequent odd numbered case was chosen and then the choice reverted to even numbers.

Initially the author approached each respondent on his own and stated his name, where he was from and briefly outlined the nature and objectives of the study. Each respondent was then asked whether they wished to take part, having been assured of confidentiality and anonymity. While most mothers agreed, one or two declined without any obvious reason. While discussing this difficulty with colleagues later on, one colleague suggested that the author resembled an insurance salesman dressed as he was in a neat blue suit and armed

with a briefcase. He suggested that the appearance of such an individual in a postnatal ward, straight off the street as it were, and without any introduction, requesting a personal interview might not always appeal to a recently delivered mother.

Bennett and Richie make reference to work suggesting that "the interviewer should avoid appearing so neat that the housewife refuses admission to her disorderly home". They also suguest that it is best not to appear too prosperous and that the plainly attired interviewer tends to be the most successful one. They advise using interviewers of the respondents own sex where possible because the communication of personal data is facilitated when interviewer and respondent are of the same sex (46). Clearly this was impossible in the present situation. Nor was it possible always to work in accordance with the suggestion that interviewer and respondents should be of the same social class. Fortunately, however, the recommendation that interviewer and respondent should be approximately the same age was relatively easy to comply with in view of the fact that the target group was women in their fertile years, and the author was in his early thirties.

The most useful suggestion from Bennett and Ritchie was that it is essential for an interviewer to gain the confidence of his respondents in order to learn personal information from them. They point out that this is greatly facilitated if he can be introduced by a person already trusted by potential respondents (46). It had rapidly become clear during the early pilot interviews that the mothers had great trust and confidence in the nursing staff on the wards. Thus, an arrangement was made whereby the interviewer was briefly introduced

to each selected respondent every morning by the sister or staff nurse on the appropriate ward. The latter were aware that the study had the approval of the Master of the hospital but were unaware of its objectives or details. They merely informed each respondent who the interviewer was and indicated he would like to talk to them later in the day in relation to a survey he was doing on maternity care. When the interviewer returned later he explained the nature and objectives of the study to each respondent and assured them of anonymity and confidentiality. It was made clear that there was no name or address on the questionnaire, but only a survey number. It was also pointed out that the interviewer had no connection with the hospital apart from having obtained permission to carry out the study there, but that he was a medical doctor. To drive home this point, the ear pieces of a stethoscope projected from the left hand pocket of the brown jacket which the interviewer had substituted for the blue suit. The briefcase had also been dispensed with. Following the revised introductory arrangements and the above cosmetic exercise, not a single respondent failed to comply with the request for an interview during the remainder of the pilot studies and during the entire main study of 150 respondents.

While the above discoveries were of major importance for ensuring a complete response, useful lessons were also learned in relation to the questionnaire itself during the first pilot study which consisted of 15 interviews. Apart from the changes in relation to the satisfaction scale already alluded to it was found that certain variables such as waiting times would be better recorded as continuous variables rather than in a precoded discrete form. This change provided a clearer picture of the mean and variance of values of the

variables in question. The section dealing with pain relief in labour was also altered considerably as a result of the pilot work. Certain other items such as hospital number date of delivery and date of interview were also dropped from the questionnaire as they were clearly not required and they could readily be determined from a special master file which was used to record details on each respondent from the birth register. Recording of the survey number on each questionnaire and on the master file entry made this information readily accessible.

Following the changes introduced as a result of the pilot survey, a second pilot survey of 5 mothers was carried out at the Coombe in order to iron out any residual difficulties. Some further minor changes were made and a final test run on five relatives and neighbours of the interviewer who had recently delivered was carried out before the final questionnaire was printed in quantity. It became clear that as Oppenmheim suggests expert advice and spurious orthodoxy are no substitutes for well organized pilot work (45).

The survey

The main survey was a relatively straightforward operation as a result of the careful pilot work. It commenced on 26th July 1984 and continued every day of the week until 12th August 1984. One hundred and fifty mothers were interviewed in all and there was not a single refusal. All were interviewed in the postnatal wards, 95% in a private room or empty day sitting-room. Five per cent of subjects were interviewed in their own beds in open wards usually because they

were post Caesarian section and because no suitable room was available nearby. However, in all of these cases curtains were drawn and the interviews took place when the ward was relatively quiet and there were no staff members present in the room.

Processing of data

The final questionnaire consisted of 77 questions, 12 of which were open-ended. The coding of closed questions was carried out during the fieldwork and the questionnaires were designed so that the data could be punched directly from the column designated "office use" without the need for a transfer sheet with its potential for introducing additional clerical error. Each evening the questionnaires were checked for completeness and accuracy.

Following completion of the fieldwork, a special coding frame was devised for each open question in accordance with the guidelines set out by Oppenheim (45). Where a mother mentioned several different items in reply to an open question only the first was coded.

The first step in the coding process consisted of writing down the central idea contained in the answers to each open question in turn. It was decided to limit the number of codes for each open question to 7 at the most in addition to the usual categories for "miscellaneous" and "no answer". A larger number would have been inappropriate bearing in mind the sample size. The objectives of the study were borne in mind when devising the codes and an attempt was made to have each category as discrete as possible. For several of the open questions relating to satisfaction similar codes emerged dealing with

items such as staff manner, hospital organisation or routine, treatment received and matters such as noise and privacy. The main purpose of these open questions was to identify reasons for satisfaction or dissatisfaction and thus careful coding was of considerable importance. All coding was done by the author. In order to increase the accuracy of the coding system a systematic sample of questionnaires was recoded by another experienced coder independently of the author. Whenever the agreement between the two coders fell below 85% the coding frame for that question was revised and the process repeated until agreement of at least 85% was achieved.

Coding for social class

The last question in the questionnaire related to social class. Because previous work in the field of consumer satisfaction with obstetric care had taken place in Britain it was decided to adopt the British Registrar General's Social Class Scale in order to allow comparisons with previous work. Thus, apart from occupation, it was necessary to determine employment status, and, in the case of employers, the number of employees employed. For coding purposes the latest edition of the OPCS Classification of Occupations was used (1980) (52).

However, it has been pointed out that the British Scale has disadvantages for survey work in Ireland because of its lack of correspondence with Irish demographic and occupational factors (53). A good example is that of farmers. The British guide does not distinguish between own-account workers without employees and employers in the farming sector. Farmers are an important group

within the Irish population structure, comprising 20% in 1971. They range from farmers with large farms of good land to marginal farmers in unproductive areas who are in receipt of unemployment assistance. To assign such a diverse group to one class as would be necessary with the British Registrar General's System is clearly inappropriate. Neither is the Irish Socio-Economic Group classification of much value for epidemiological purposes as it is purely a nominal grouping of occupations and not an ordinal scale.

O'Hare's 6-point Irish social class scale is a major advance in this area as it is an ordinal scale and also it classifies farmers according to acreage. Census data will in future be available, classified according to this scale.

As stated above, the British Registrar General's Scale is used for this analysis of the survey. The problem of farmers was insignificant as only one respondent was married to a farmer. However, each case was also coded according to O'Hare's scale (54) so that data could be later re-analysed for publication in Irish journals. This has the advantage that future worker's in this field in Ireland can compare their findings with the present study.

Social class coding was based on husband's occupation in order to allow comparisons to be made with the work of Kirke (25) and Cartwright (7).

Analysis

Data was processed from the questionnaires on to magnetic tape and was

analysed using the Statistical Package for the Social Sciences (SPSS) programme (55) on the Digital DEC 2060 computer at University College Dublin. The computer analysis was carried out by the author. A series of checks was performed initially to identify obvious errors. These checks included range checks on quantitative variables such as age and parity. Checks for internal consistency between codes were also done. Error rates of less than 0.5% were found. Frequency distributions were also obtained on all variables. Any errors detected were corrected in the data file. The data occupied the equivalent of approximately 1.5 IBM punch cards per case.

Interrelationships between variables were examined using SPSS subprogram T-test and Crosstabs (55). The T-test subprogram was used for testing the difference between means of quantitative variables, for example, the difference in mean age or length of waiting time between those satisfied and those dissatisfied with their antenatal care.

The Crosstabs subprogram was used for examining differences between qualitative variables. Most of the analysis involved 2 x 2 contingency tables, although some more complex tabulations were used to study interrelationships between several variables. The test of significance used with the crosstabs subprogram was the chi-squared test, with Yate's correction when 2 x 2 tables were being used. Fisher's exact test was used whenever there were less than 21 cases.

An attempt was made to develop a new composite index of overall satisfaction by combining the answers to seven questions regarded as key indicators of satisfaction into a single quantitative variable

using the SPSS data modification cards (55).

The seven key questions concerned satisfaction with antenatal care, satisfaction with nurses and doctors during labour and delivery and on the postnatal wards, satisfaction with management of pain during labour and willingness to return to the hospital in the event of a future pregnancy. Each question on satisfaction was scored as follows: dissatisfied = 0, satisfied with reservations = 1, satisfied = 2. The question on willingness to return to the hospital was scored as follows: not willing to return 0, willing to return 2. Each patient's score for each of these questions was added up and divided by 7 minus the number of questions not answered. This enabled a comparison to be made between those who answered any or all of the 7 key questions. This resulted in a scale ranging from 0 to 2 which in turn was multiplied by 50 in order to give a score ranging from 0 to 100.

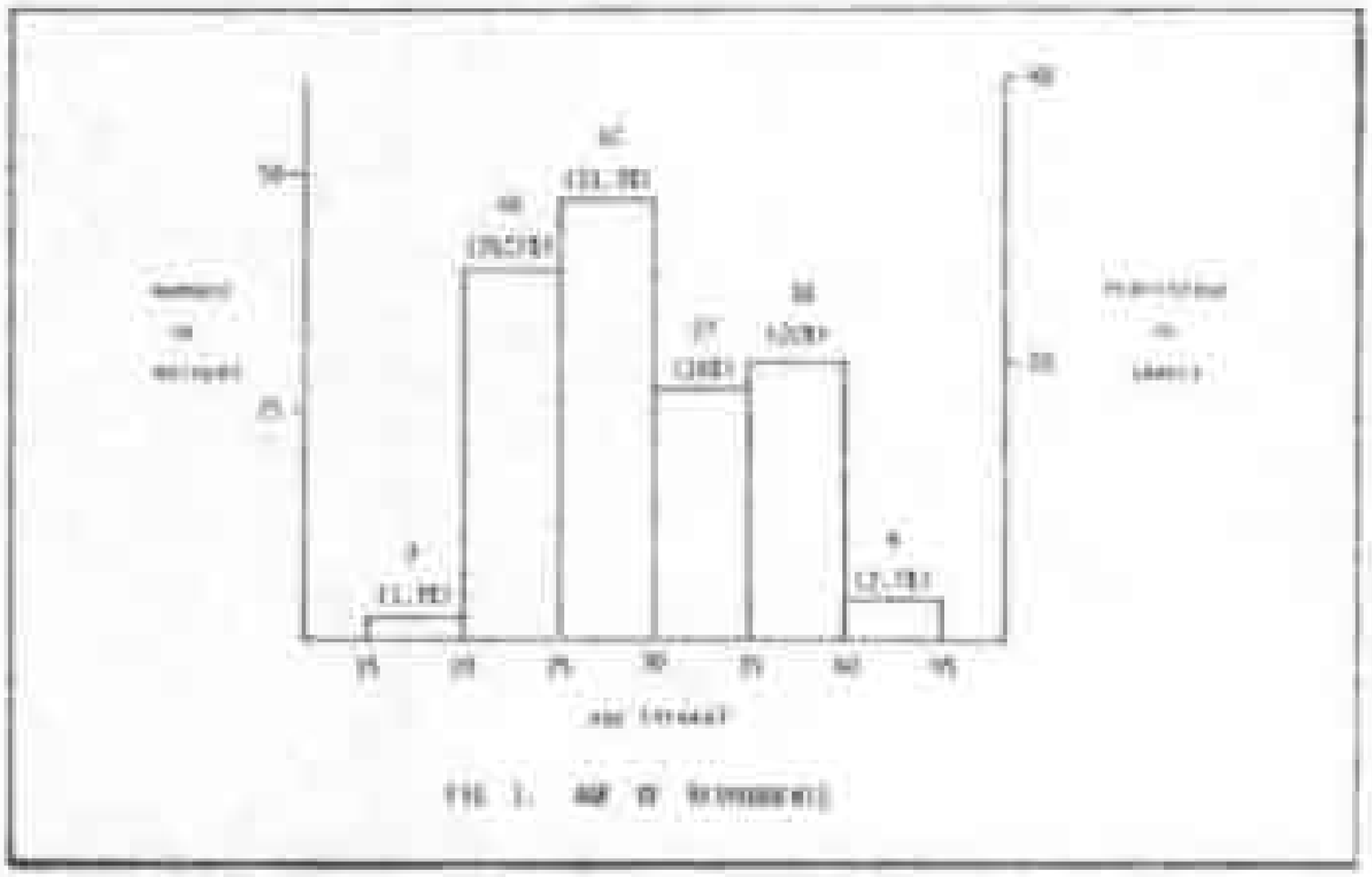
The interrelationship between this new variable and other quantitative variables such as age was examined using SPSS subprogram Scattergram with Pearson's product moment correlation and a two-tailed test of significance (55). The relationship between the new variable and other qualitative variables was examined using subprogram Crosstabs.

RESULTS

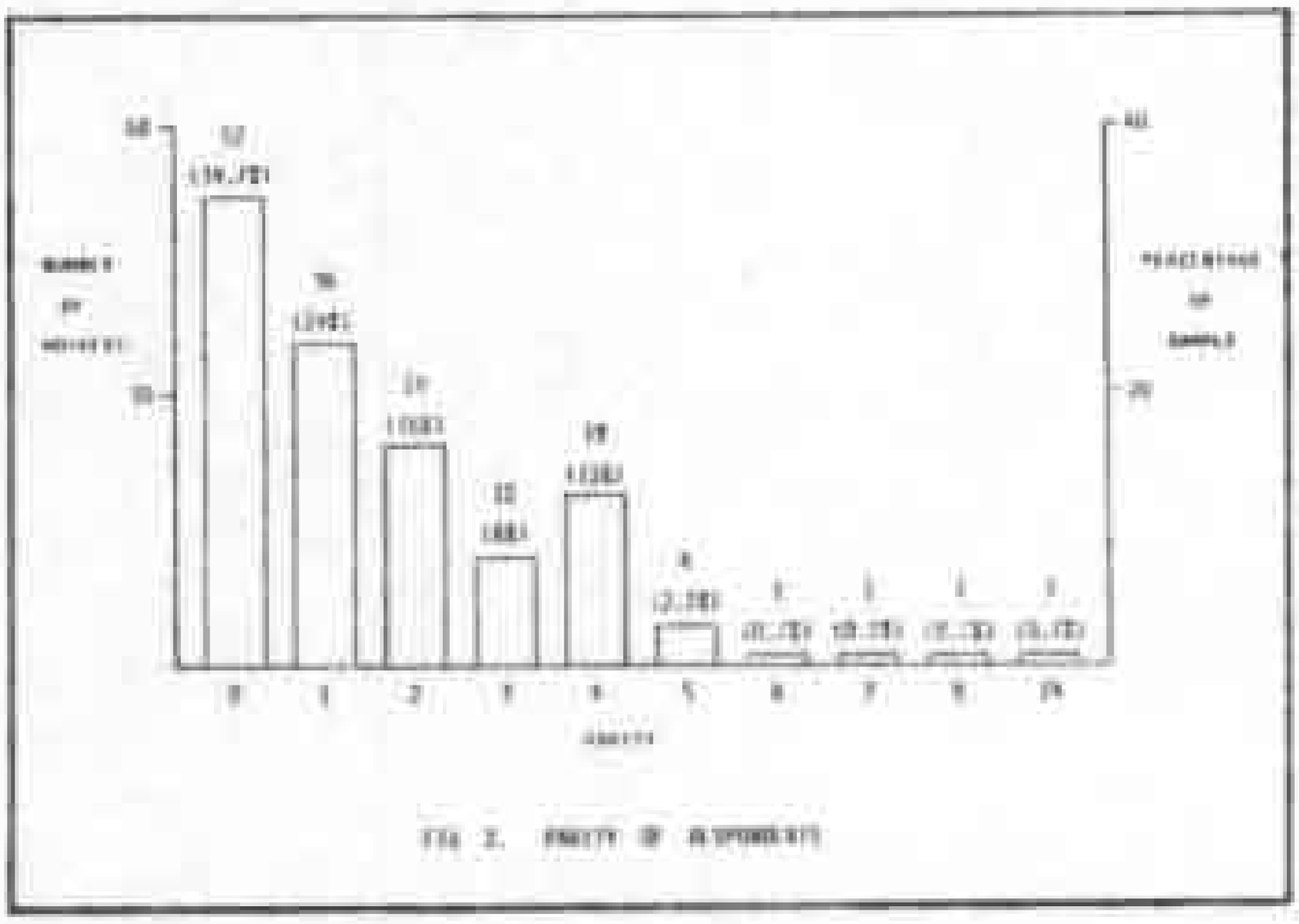
The results of the interviews with the 150 mothers are presented in this section. There are five main areas of concern - antenatal care, labour and delivery, postnatal care, additional information of interest and overall satisfaction. However, first some basic data on the characteristics of the mothers will be presented. Where significance tests have been done p values are given in brackets when the difference reaches conventional levels of statistical significance. Where the difference is not significant this is indicated by (NS).

CHARACTERISTICS OF MOTHERS

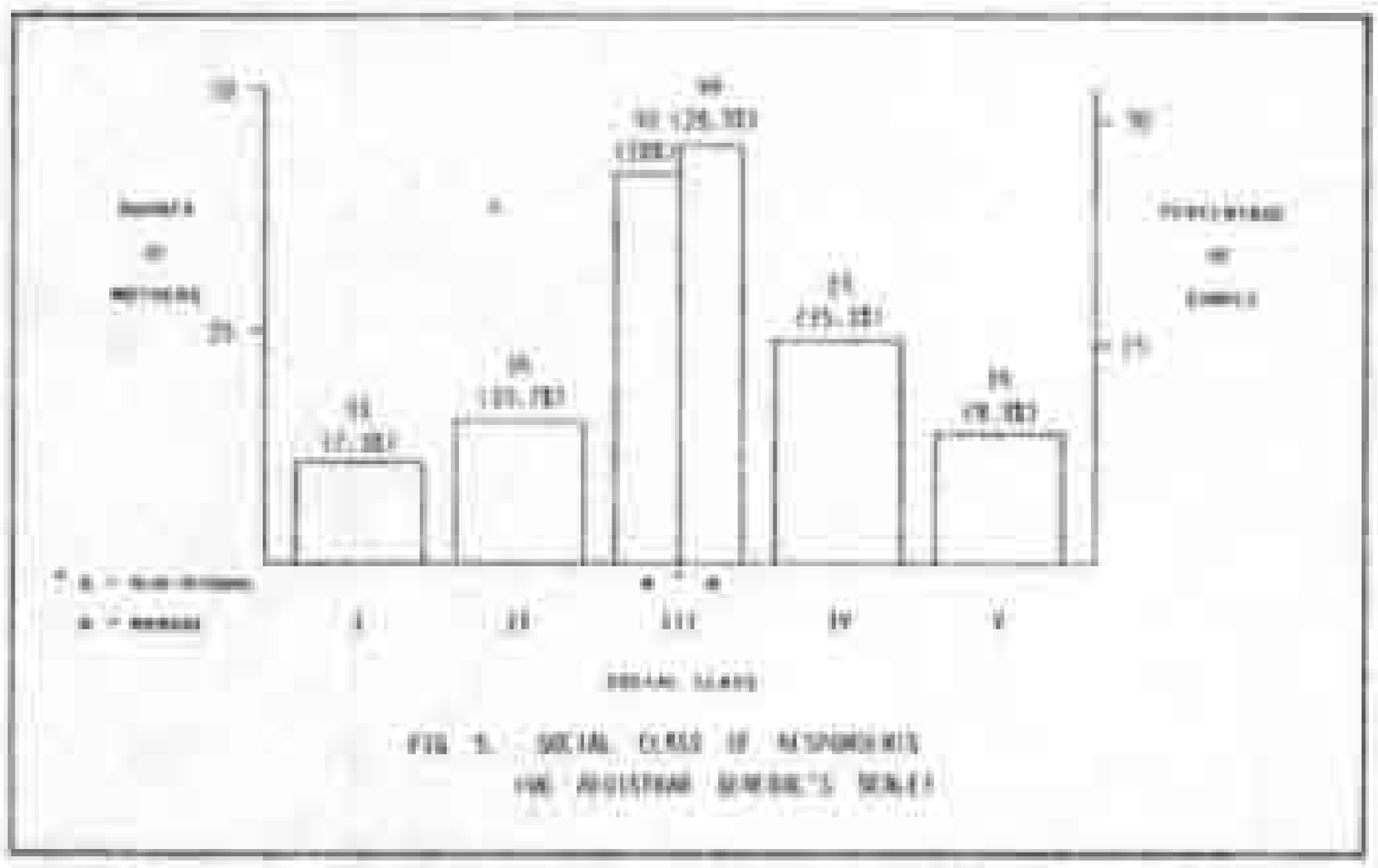
1. Age: The mean age of mothers in the sample was 28.9 years with a range from 19 to 44 years (see Fig. 1). As can be seen from Fig. 1, only 1.3% of the sample were aged under 20 whereas 22.7% were aged over 35.



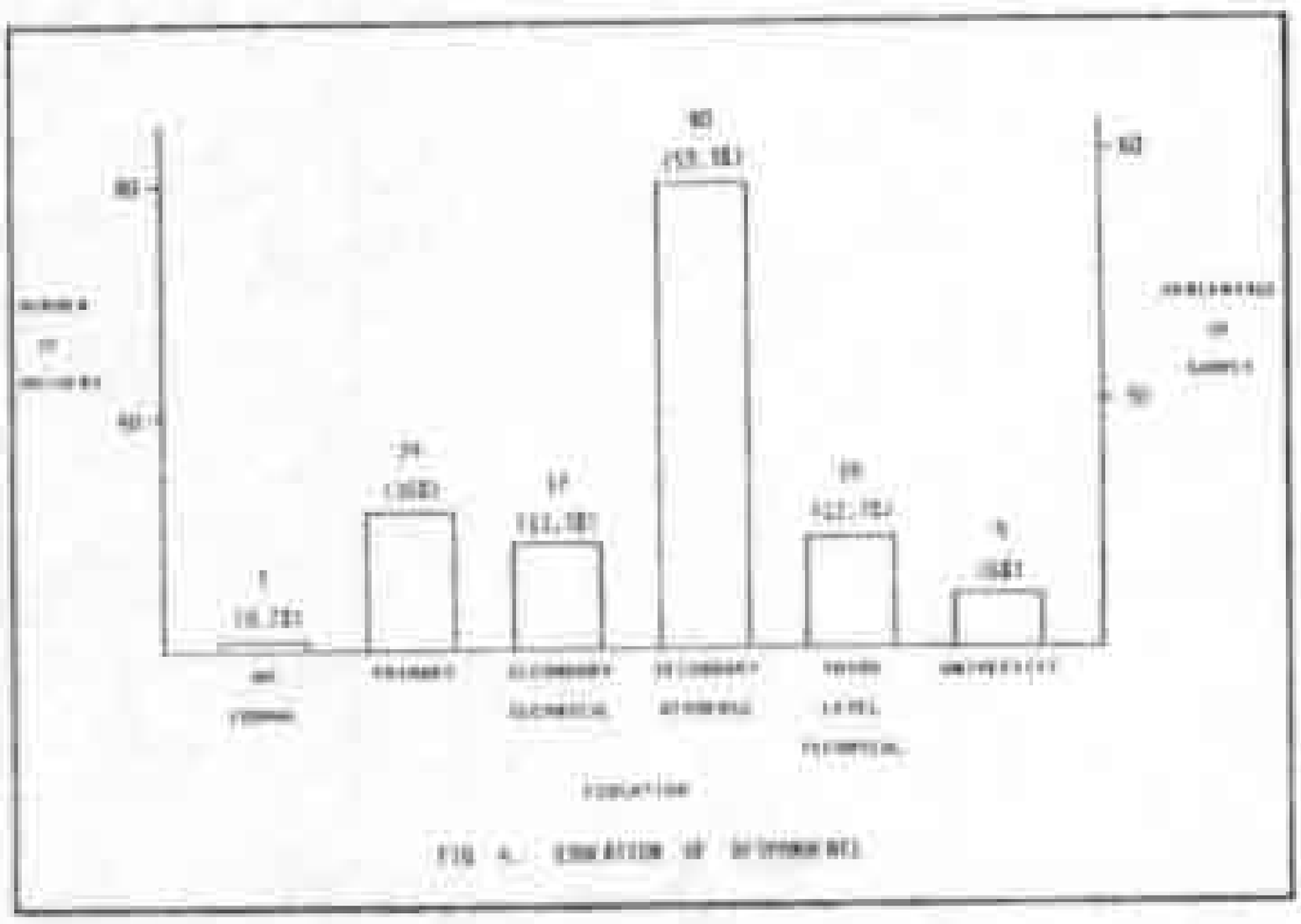
2. Parity: The mean parity of the sample was 1.7 with a range from 0 to 14 (see Fig. 2). 34.7% of the sample were primigravidae and 17.5% were para 4 or higher.



3. Social Class: Figure 3 shows the distribution of the mothers in the various social classes, in accordance with the British Registrar General's Scale. 57.3% of the sample were in Social Class III.



4. Education: Figure 4 shows the distribution of the mothers in the various educational groups. Three-quarters of the sample were educated to a standard above primary, but only 19% had third level education.



5. Residence: One hundred (66.7%) of the respondents were resident in Dublin City or County. Fifty (33.3%) were resident outside Dublin.

6. Health Service Eligibility Status and Medical Insurance: Twenty-seven (18%) of the respondents were covered by medical cards, i.e. they were persons with full eligibility entitled to the full range of health services without charge. The remaining 123 (82%) of respondents were not covered by medical cards.

Forty-seven (31.3%) of the respondents were covered by private medical insurance by being members of the Voluntary Health Insurance (VHI) scheme.

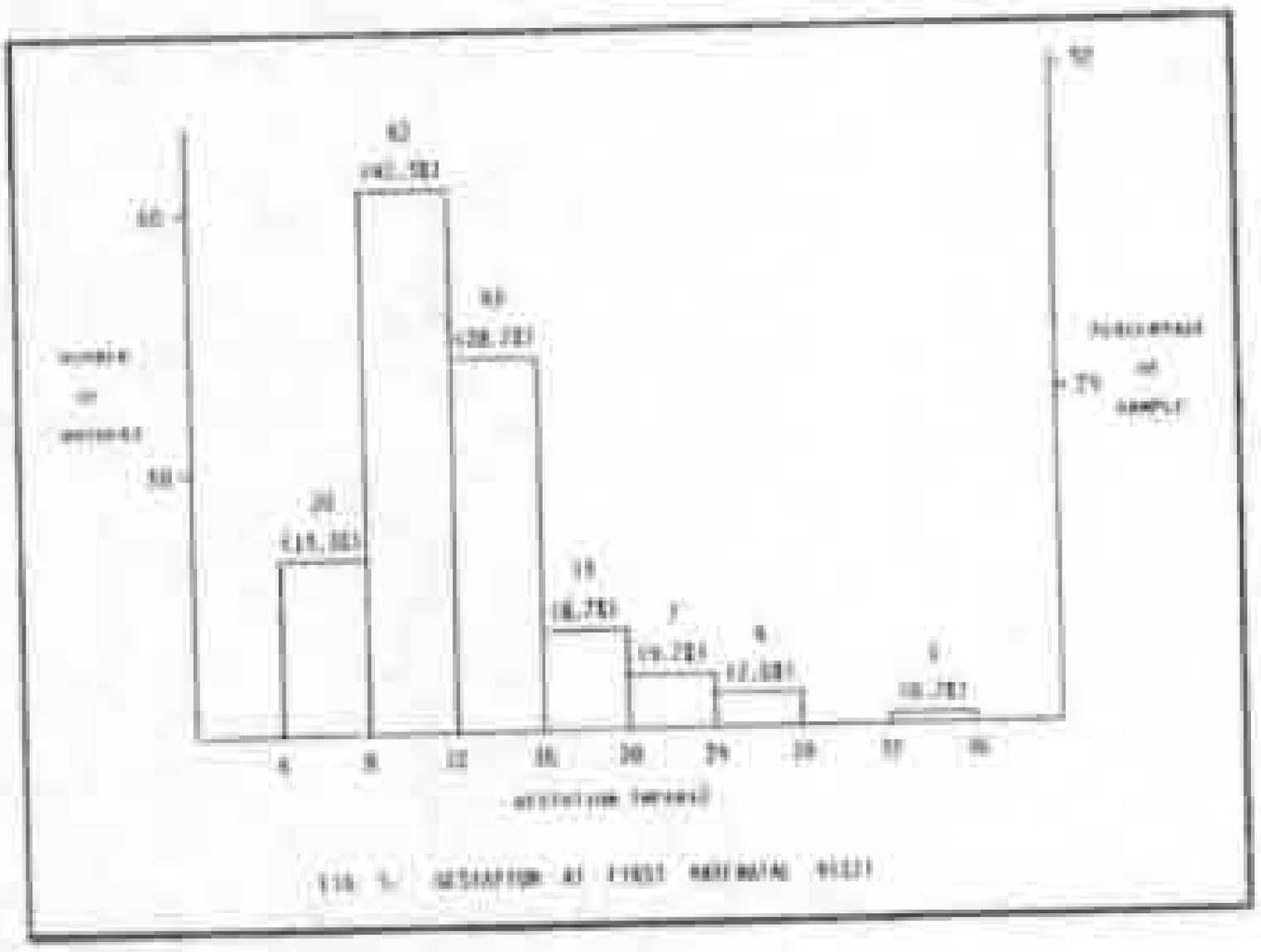
ANTENATAL CARE

Several aspects of antenatal care were studied. These included doctor-patient communication, antenatal classes, overall satisfaction with care and a comparison of general practitioner (GP) and hospital antenatal care. However, a number of general findings will be presented before the details of these areas are discussed.

Firstly, on the question of type of care chosen, 78 mothers (52%) attended the public clinic in the Coombe itself, while another 15 (10%) attended clinics run by Coombe staff in peripheral health board premises. In other words 62% of mothers received antenatal care as public patients. Another 24 mothers (16%) attended the hospital semi-private clinic while 33 (22%) attended the obstetrician of their choice privately. Thus 38% of mothers received care as semi-private or private patients.

Fifty-three patients (35.3%) availed of the combined care scheme where care was shared between hospital and G.P.

The mean gestational age at the time of the first antenatal check-up was 13.8 weeks with a minimum of 4 weeks and a maximum of 34 weeks. As can be seen from Fig. 5, 83.3% of mothers attended before or during the fourth month of pregnancy with 8.7% attending during the fifth month and 8% after the fifth month.



Once mothers attended for antenatal care they were likely to continue to attend. Only 12% missed antenatal appointments, half of whom missed just one appointment.

The mean length of time spent having an antenatal check was 53 minutes including waiting time, with a minimum of 10 minutes and a maximum of 2 hours. These figures refer to attendances at hospital or health based clinics. A more detailed breakdown may be seen in Table 1.

TABLE LENGTH OF TIME SPENT AT CLINIC (MINUTES)

	Minimum	Mean	Maximum
Public clinic - hospital	20	59	120
Public clinic - Health Board	15	64	150
Semi-private clinic	20	61	120
Private clinic	10	29	70

Communication during antenatal care

One hundred and nineteen mothers (79.3%) asked the doctors questions during clinic check-ups. Forty-six per cent of mothers said the doctors usually explained things without having to be asked; 26.7% said the doctors rarely volunteered information and an identical percentage said they never did so. Only one mother said that there was no need for explanations as she knew sufficient already.

One hundred and two mothers (68%) were able to find out all they wanted about their pregnancy during their visits to the clinic, but only 84 (56%) felt they had enough opportunity to ask questions at the check-ups.

These two results appear somewhat inconsistent, but a possible explanation is that the majority of mothers managed to find out by their own efforts what they wanted to know in the face of a clinic environment which did not encourage questions or discussion. However, it is important to note that 44% of the sample did not have enough opportunity to ask questions and 32% did not find out all they wanted to know.

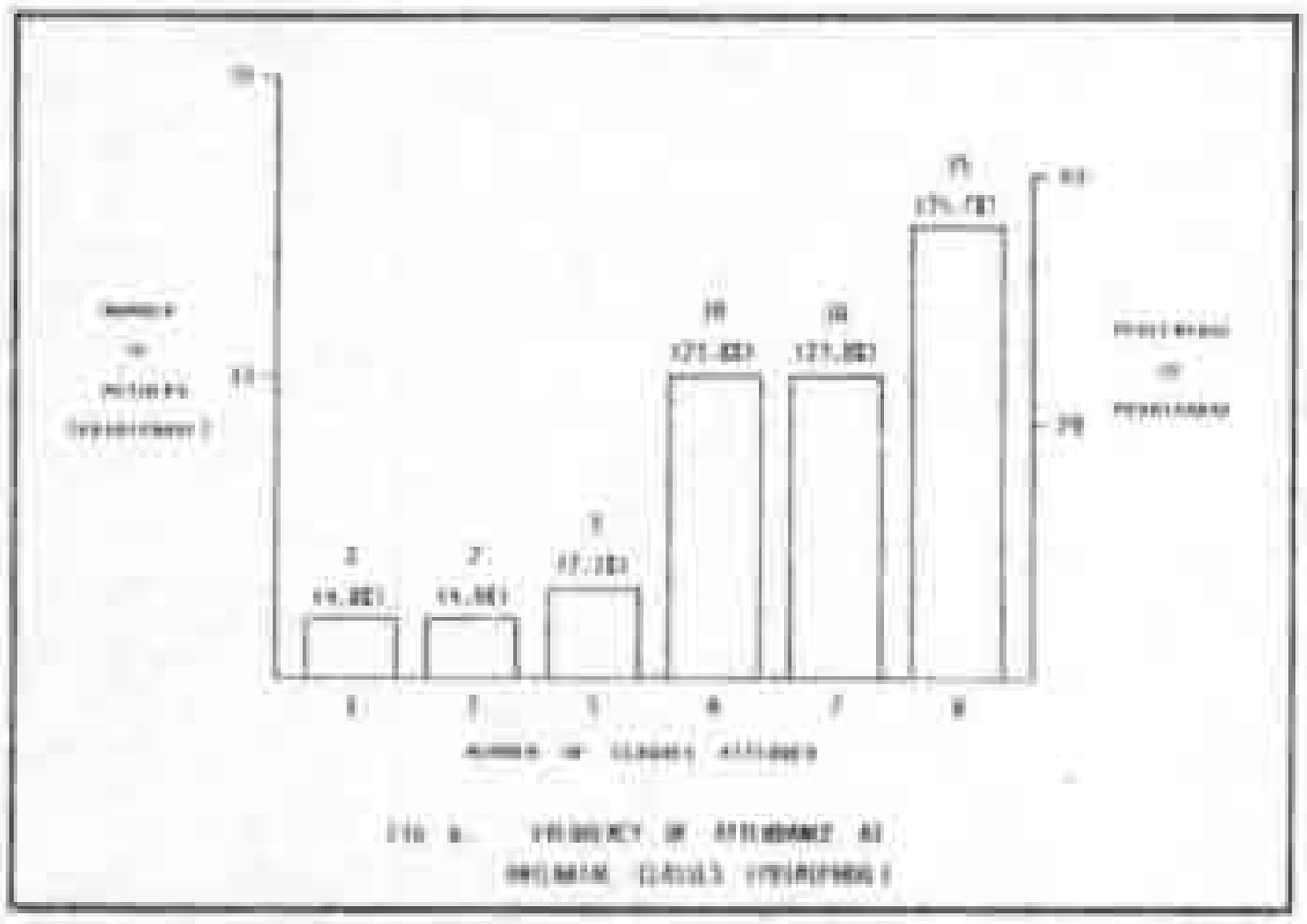
The relationship between the various questions on communication and a number of patient characteristics was examined. There was no significant relationship between asking questions, perceived opportunity to ask questions, amount of explanation received by mothers and ability to find out as much as was wanted, and the parity or social class of the mothers. However, 92.9% of mothers with third level education asked questions at their hospital antenatal check-ups

as against 79.4% of those with secondary education and 64% of those with primary education ($p < 0.05$).

Private and semi-private patients fared better than public only as regards communication. 73.7% of private and semi-private patients felt that they had sufficient opportunity to ask questions as against 45.2% of public cases ($p < 0.001$). 82.5% of private and semi-private patients found out as much as they wanted during their antenatal check-ups as against 59.1% of public patients ($p < 0.01$). 57.9% of private and semi-private patients felt that their doctor usually volunteered information as against 38.7% of public patients, while 12.3% of private and semi-private patients said that the doctor rarely volunteered information as against 35.5% of public patients ($p < 0.05$).

Antenatal classes

Forty-two mothers attended antenatal classes. This figure respresents 81% of all primigravidae and it is quite a high figure. Only 4 multiparae attended the refresher class, a disappointing figure representing only 4% of all multiparae. Figure 6 shows the frequency of attendance of those primigravidae who did attend antenatal classes. It may be seen that 83% of all primigravieae attended six or more of the series of eight classes.



When asked IF the classes helped, of the 46 mothers who attended classes, 59% said that they helped "a lot", 26% said a "fair bit" and 15% said "not much".

Private and semi-private primigravid patients were not significantly more likely to attend antenatal classes (79%) than public patients (61%). The non-manual classes were not significantly more likely to attend (79%) than the manual classes (61%). Thirty-three per cent of those with primary education or no education were attenders, while 74% of those with secondary education and 80% of those with third level education attended classes (NS).

G.P. antenatal care

Fifty-three mothers attended their G.P. under the combined antenatal care scheme. The mean length of time spent at the G.P.'s surgery for an antenatal check-up was 36 minutes, 17 minutes less than at hospital

clinics. The minimum time was 5 minutes and the maximum 1 hour 55 minutes.

Forty-three mothers (81%) asked their G.P. questions - which is very similar to the proportion who asked questions at the hospital. In 33 cases (61.3%) the G.P. usually explained things without having to be asked. In six cases (11.3%) he/she rarely volunteered explanations and in 14 cases (26.4%) he/she never did. Forty-five mothers (85%) had enough opportunity to ask their G.P. questions, a considerably higher proportion than in the case of the clinic and 45 (85%) were able to find out all they wanted about their pregnancy during their visits to the G.P. These results are more consistent than those from the hospital clinic which have already been discussed.

Of the 53 mothers who availed of combined antenatal care 47% preferred the G.P. aspect of the care, while 34% preferred the hospital aspect and 19% had no particular preference.

Satisfaction with antenatal care

Sixty-eight per cent of mothers expressed themselves satisfied with their antenatal care while 26% were satisfied with reservations and 5% were dissatisfied. Because the number who were dissatisfied is so small (9 cases in all), for the purposes of most analyses the dissatisfied group and the satisfied with reservations group have been combined, giving a total of 48 cases. This new grouping will be referred to as the 'dissatisfied' group.

The mean age of the dissatisfied mothers was 27.1 years whereas the

satisfied group were older - 29.7 years ($p < 0.05$).

There was no major difference in levels of satisfaction between primigravidae and multiparae, (see Table 2).

TABLE 2 SATISFACTION WITH ANTENATAL CASE IN RELATION TO PARITY

	Parity			
	Primiparae		Multiparae	
	No.	%	No.	%
Satisfied	33	63.5	69	70.4
Dissatisfied	4	7.7	5	5.1
Satisfied with reservations	15	28.8	24	24.5
Total	52	100	98	100

x^2 test (2 d.f.)* = 0.87 (NS)

* = degrees of freedom

Somewhat more of those with secondary education (35.1%) were dissatisfied with antenatal care than those with primary education alone (28%) or with third level education (25%) (NS).

As regards social class 71% of the non-manual classes were satisfied as against 65.4% of manual classes (NS). However, as can be seen from Table 3, the relationship is somewhat more complex, and there is a tendency for those in social classes II, III and IV to be less satisfied than those in social classes I or V.

TABLE 3 SATISFACTION WITH ANTENATAL CARE IN RELATION TO SOCIAL CLASS

	Social Class									
	I		II		III non-manual		III manual		IV	V
	No.	%	No.	%	No.	%	No.	%	No. %	No. %
Satisfied	11	100	10	62.5	28	66.7	28	63.6	14 60.9	11 78.6
Dissatisfied or satisfied with reservations	0	0	6	37.5	14	33.3	16	36.4	9 39.1	3 21.4
Total	11	100	16	100	42	100	44	100	23 100	14 100

X^2 test (5 d.f.)* = 1.08 (NS)
* U.K. Registrar General Social Class Scale.

Significantly more private and semi-private patients than public patients were satisfied with their antenatal care (see Table 4). Similarly 85% of those with Voluntary Health Insurance were satisfied as against 60.2% of those without it ($p < 0.01$). Surprisingly in view of the above results, possession of a medical card was a poor predictor of satisfaction; 66.7% of those with a medical card were satisfied as against 68.3% of those without a card.

TABLE 4 SATISFACTION WITH ANTENATAL CARE IN RELATION TO PUBLIC/PRIVATE CARE

	Type of Antenatal Care			
	Public		Private/Semi-Private	
	No.	%	No.	%
Satisfied	53	57	49	86
Dissatisfied or satisfied with reservations	40	43	8	14
Total	93	100	57	100

X^2 test (1 d.f.) = 12.34 ($p < 0.001$).

More mothers from rural areas (80%) were satisfied with antenatal care

In comparison to mothers from Dublin (62%) ($p < 0.05$).

Dissatisfied mothers tended to ttend for antenatal care slightly later (14.4 weeks) than those in the satisfied group (13.5 weeks) (NS).

The dissatisfied group had to wait considerably longer at the antenatal visits, 60.6 minutes as against 49.7 minutes for the satisfied group ($p<0.05$).

Satisfaction in relation to communication

More mothers who asked questions at the antenatal clinics were satisfied in comparison to those who did not ask questions (see Table 5). Thus it appears that the more diffident patient may be less happy with her care than the patient who adopts a questioning approach.

TABLE 5 SATISFACTION WITH ANTENATAL CARE IN RELATION TO MOTHERS WHO ASKED QUESTIONS AT ANTENATAL CLINICS

	Whether Mother asked Questions			
	Yes		No	
	No.	%	No.	%
Satisfied	86	72.3	16	51.6
Dissatisfied or satisfied with reservations	33	27.7	15	48.4
Total	119	100	31	100

X^2 test (1 d.f.) = 3.92 ($p<0.05$)

There was a strong association between satisfaction with antenatal care and the degree to which doctors volunteered information at the clinic (see Table 6), suggesting that this is one of the most important factors related to satisfaction.

TABLE 6 SATISFACTION WITH ANTENATAL CARE IN RELATION TO FREQUENCY WITH WHICH DOCTORS VOLUNTEERED INFORMATION IN THE CLINICS

	Frequency with which Doctor Volunteered Information					
	Usually		Rarely		Never	
	No.	%	No.	%	No.	%
Satisfied	63	91.3	22	55.0	16	40.0
Dissatisfied or satisfied with reservations	6	8.7	18	45.0	24	60.0
Total	69	100	40	100	40	100

X^2 test (2 d.f.) = 35.21 ($p < 0.0001$)

•1 mother said there was no need for any explanations as she knew enough already. Thus the total number of cases in this analysis is 149.

Similarly, ability to find out all they wanted about the pregnancy was strongly associated with satisfaction (see Table 7).

TABLE 7. SATISFACTION WITH ANTENATAL CARE IN RELATION TO ABILITY TO FIND OUT AS MUCH AS WISHED ABOUT PREGNANCY

	Whether mother found out all she wanted			
	Yes		No	
	No.	%	No.	%
Satisfied	90	88.2	12	25.0
Dissatisfied or satisfied with reservations	12	11.8	36	75.0
Total	102	100	48	100

X^2 test (1 d.f.) = 57.11 ($p < 0.0001$)

The opportunity to ask questions at the clinic was also strongly associated with satisfaction (see Table 8). Thus, there is good evidence that satisfaction is strongly related to communication

between doctor and patient in the antenatal clinic.

TABLE 8. SATISFACTION WITH ANTENATAL CARE IN RELATION TO OPPORTUNITY TO ASK QUESTIONS

	Opportunity to ask Questions			
	Enough		Not Enough	
	No.	%	No.	%
Satisfied	77	91.7	25	37.9
Dissatisfied or satisfied with reservations	7	8.3	41	62.1
Total	84	100	66	100

X^2 test (1 d.f.) = 46.7 ($p < 0.0001$)

Satisfaction with antenatal care in relation to attendance at antenatal classes

Of the 38 primagravidae who attended antenatal classes 60.5% were satisfied with their antenatal care whereas 71.4% of the 14 non-attenders were satisfied (NS). There was a significant association between satisfaction with antenatal care and how helpful mothers found the classes (see Table 9).

TABLE 9 SATISFACTION WITH ANTENATAL CARE IN RELATION TO HELPFULNESS OF ANTENATAL CLASSES

	Degree of helpfulness of classes					
	A Lot		A Fair Bit		Not Much	
	No.	%	No.	%	No.	%
Satisfied	13	56.5	9	90.0	1	20.0
Dissatisfied or satisfied with reservations	10	43.5	1	10.0	4	80.0
Table	23	100	10	100	5	100

x^2 test (2 d.f.) = 7.23 ($p < 0.05$)

Satisfaction with antenatal care in relation to combined care scheme

Of the 53 mothers who availed of combined antenatal care, 40% were dissatisfied with their overall antenatal care, a somewhat higher proportion than in the sample as a whole, (32%). The satisfied and dissatisfied groups did not differ significantly as regards age, waiting time, parity, public or private care, Voluntary Health Insurance status or possession of a medical card. However, the findings in relation to social class were similar to those for the sample as a whole. All of those in Social Classes I and V were satisfied, whereas the proportions dissatisfied in Classes II, III, IV were 50%, 47% and 30% respectively (NS).

Findings in relation to doctor-patient communication were similar to those for the sample as a whole. Fifty-four per cent of the mothers who asked their G.P. questions were satisfied as aginst 80% of those who did not ask questions (NS). Thirty-three per cent of those who felt they had enough opportunity to ask questions were dissatisfied as aginst 75% of those who did not have sufficient opportunity (NS). Sixty-three per cent of those who were not able to find out as much as they wanted from their G.P. were dissatisfied as against 36% of those who were (NS). Sixty-four per cent of patients who said the G.P. usually volunteered Informtion were satisfied as against 13% and 22% respectively for those whose G.P.'s rarely or never volunteered information.

Reasons for satisfaction and dissatisfaction

Respondents were asked if there was any aspect of their antenatal care with which they were particularly pleased or were unhappy about. This was felt to be an important aspect of the study as there would be little value in finding out that women were dissatisfied unless it was possible also to identify reasons for dissatisfaction.

Forty-one per cent of mothers (88) passed some favourable comment about their antenatal care. Table 10 gives an idea of the sort of remarks made. Sixty-six per cent of satisfied mothers made some favourbie comment on their antenatal care, whereas 44% of dissatisfied mothers did so. As can be seen in Table 10, favourable comments on the staff and on classes are most prominent among both satisfied and dissatisfied groups.

TABLE 10 FAVOURABLE COMMENTS PASSED BY MOTHERS ON THEIR ANTENATAL CARE IN RELATION TO SATISFACTION WITH CARE

	Satisfaction Status			
	Satisfied		Dissatisfied	
Favourable comments about:	No.	%	No.	%
Antenatal classes	14	13.7	9	18.8
Staff	33	32.4	9	18.8
Seeing same doctor every visit	5	4.8	1	2.1
Organization of clinic	6	5.9	1	2.1
Treatment	7	6.9	0	0.0
Miscellaneous comments	2	2.0	1	2.1
No comment	35	34.3	27	56.3
Total	102	100	48	100

Seventy-four mothers (49.3%) passed some unfavourable comment on their antenatal care. One hundred per cent of the 48 dissatisfied mothers

passed an unfavourable comment, whereas only 27.5% of satisfied mothers did so. These figures suggest that the question on satisfaction/dissatisfaction may be reasonably valid. The nature of the unfavourable comments made may be seen in Table 11. The major area of dissatisfaction relates to being rushed at the clinic and getting too little information from the doctors. This finding is in agreement with the responses to the questions on communication (Tables 5, 6, 7, 8), and is therefore an indication that the questions are reasonably valid. The comments on clinic organization refer to problems such as having to queue up for long periods for weighing. Several women suggested that provision of additional scales would be an advantage.

TABLE 11 UNFAVOURABLE COMMENTS PASSED BY MOTHERS ON THEIR ANTENATAL CARE IN RELATION TO SATISFACTION WITH CARE

Unfavourable comments about:	Satisfaction Status: Satisfied No.	Satisfied %	Dissatisfied No.	Dissatisfied %
Felt rushed at clinic, too little information	8	7.9	32	66.7
Waiting too long	8	7.9	1	2.1
Organisation of clinic	4	3.9	9	18.8
Not seeing same doctor each time	1	1.1	0	0.0
Manner of staff	3	2.9	5	10.3
Treatment	1	1.0	0	0.0
Miscellaneous comments	3	2.9	1	2.1
No comment	74	72.5	0	0.0
Total	102	100	48	100

CARE IN LABOUR AND DELIVERY

While the main objective of this section was to determine how satisfied mothers were with care received during labour and delivery, a number of other aspects of labour and delivery were also examined, particularly in relation to amount of explanation received by mothers. These include induction, monitoring, delivery itself, position at delivery, analgesia, early bonding, anxiety levels and company in labour and delivery. These will be briefly presented before the question of satisfaction is looked at in detail.

Induction

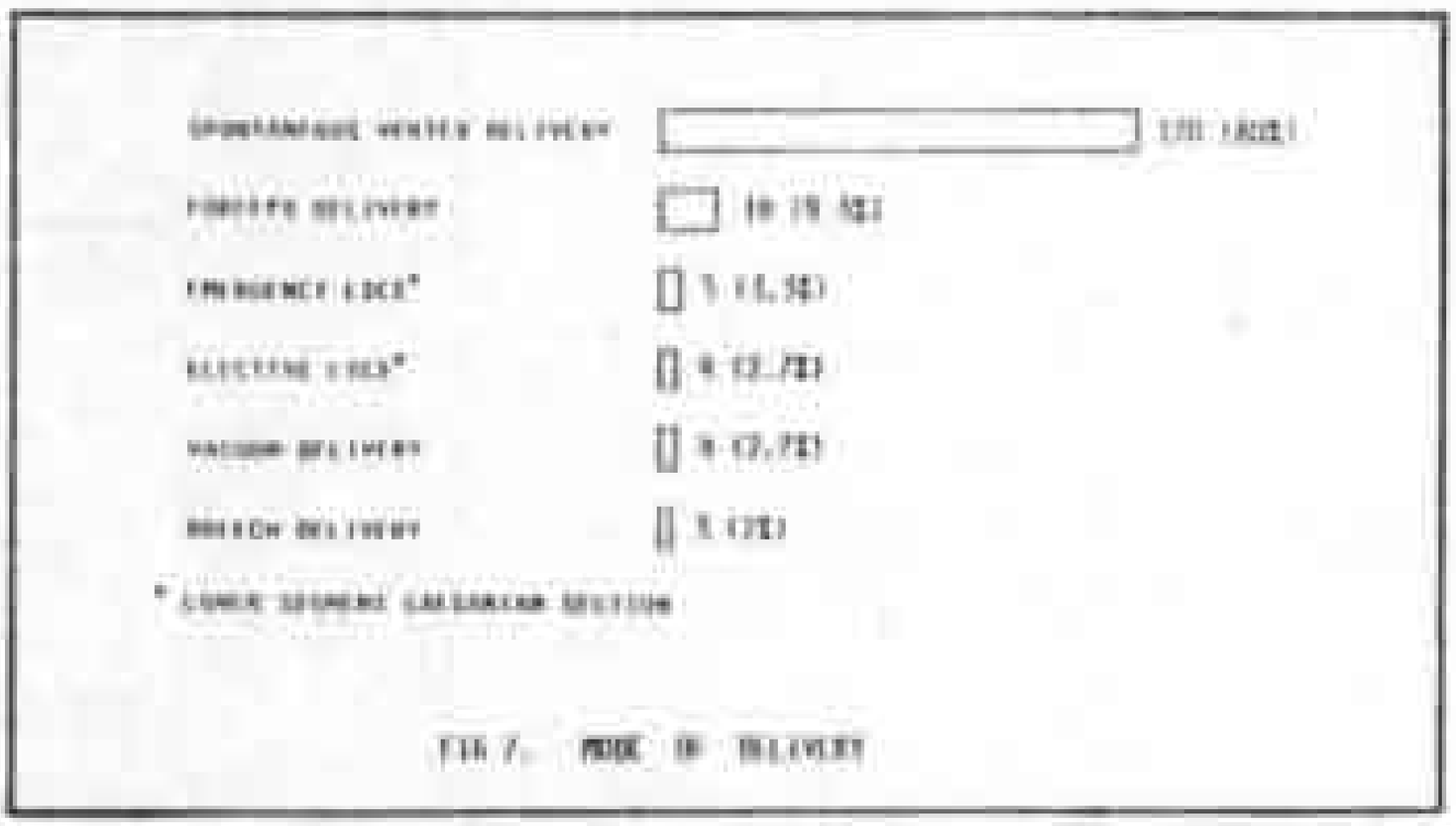
The induction rate was 22.7%, i.e. 34 women in all were induced. In 85.3% of cases, the staff explained why the mother was being induced, without her having to ask. In 5.9% of cases the patient asked why she was being induced, and the staff explained. One patient asked for an explanation but did not receive one. In 5.9% of cases the patient did not ask and the staff did not explain.

Monitoring

35.3% of mothers had electronic fetal heart monitoring during labour (53 cases in all). In 75.5% of these cases the staff explained why this was done without the patient having to ask. In 17% of cases an explanation was neither asked nor offered. In 7.5% of cases the patient asked for and got an explanation. 75.5% of those monitored felt more secure during labour because of the monitoring. 9.4% felt less secure and 15.1% felt neither more secure nor less secure.

Mode of delivery

There were 120 spontaneous vertex deliveries in the sample (i.e. 80% of the total). Figure 7 shows the frequency of the various modes of delivery. The caesarian section rate was 6% with the forceps/vacuum rate 12%. The latter is rather higher than expected, the rate for the hospital in 1983 being 6.5% (49).



In 81.5% of instrumental deliveries the reason for the intervention was explained to the mother without her having to ask. In 11.1% of cases an explanation was neither asked nor given. In 3.7% of cases the patient asked for and received an explanation and in 3.7% she asked for but did not receive an explanation.

Position at delivery

Of the 120 spontaneous vertex deliveries, 85% delivered in the dorsal

position, some partly propped up; 13.3% delivered in the delivery chair and 1.7% delivered on their side.

When asked which position they would prefer for giving birth, 62.1% said their back, 26.2% said the chair, 1.4% said their side, 0.7% said squatting and 9.7% had no partricular preference.

Early contact with baby

Mothers were asked whether they had held their baby immediately after birth and if so whether they had held it for long enough or for too long. Nine mothers were not in a position to be able to hold the baby immediately as they were sectioned under general anaesthetic. Of the remaining 141 cases 95.7% held their baby immediately after birth and for long enough, 2.8% did not hold the baby for long enough and 1.4% did not hold it until they had left the delivery suite.

Analgesia in labour

In an attempt to find out how mothers felt about the idea of "natural birth", they were asked whether, prior to going into labour, they had intended to take any painkillers once labour started. 22.7% said that they had definitely intended not to have painkillers, while 40.7% said that they would only take them if the pain was very bad. 25.3% definitely intended to have painkillers and 8% had no definite plan. 3.3% understood that they would probably have an elective caesarian section.

Mothers were then asked whether they were offered something for pain

once they were in labour or whether they had to ask for it. 70.7% were offered analgesia by the staff, 17.3% asked for it and 1.3% neither asked nor were offered. In 7.3% of cases labour was too advanced for any medication. 3.3% had elective caesarian sections. 54.7% of mothers had pethilorfan by injection, 58% had inhalational analgesia and 5.3% had epidural analgesia.

Five mothers had an elective caesarian section, 11 were too far advanced in labour by the time of admission to get any analgesics and two felt that their pain was not bad enough to require anything. Of the remaining 132, 81.8% were satisfied with how their labour pains were managed, 11.4% were satisfied with reservtions and 6.8% were dissatisfied. When asked whether they were satisfied with the way that their pain in labour was managed, 15.9% of those who had pethilorfan were dissatisfied or satisfied with reservations as against 19.5% of those who had inhalational analgesia and 50% of those who had an epidural.

Anxiety during labour and delivery

When asked about anxiety in labour, 50.7% said they were calm during labour, 29.3% were slightly anxious and 16.7% were very anxious at some point; 3.3% had elective caesarian sections and thus did not experience labour.

The figures for delivery were similar. 49.3% were calm, 28.7% slightly anxious and 16% very anxious, 6% had caesarian sections (elective and emergency).

Company during labour and delivery

A surprisingly high percentage (15.2%) were left alone at some point during labour. However, all said that this was only for a few moments while the nurse went to get something.

Presence of husband

Fifty-two per cent of mothers had their husband present for both labour and delivery. In 16.7% of cases he was there for labour only and in 0.7% for delivery only. In 27.3% he was present for neither and 3.3% had elective sections.

When those whose husbands were present all the time and those who had elective caesarian sections were excluded, the remaining group, i.e. those whose husband was not present for labour or delivery or neither, were asked why he was not there, the following were the answers: in 40.9% of cases the mother did not want him there, in 25.8% he did not want to be there, in 24.2% he was unable to be there even though both would have liked it (domestic reasons etc.), and in 9.1% of cases the hospital would not allow it (difficult delivery).

Manner of staff during labour

In 23.3% of cases the patient reported that no doctor was present during labour or delivery, although in some of these cases she may have confused female doctors for nurses or may have forgotten that she had seen a doctor at the time of admission. Some of these cases did have a doctor after delivery for stitching. When this group plus

those who had elective caesarian sections were excluded, 86% of the remainder said that their doctors had been sympathetic, 12% said they were not sympathetic and 2% said some were sympathetic and some were not.

When asked about how sympathetic the nurses were, having excluded those having elective sections, 88% said their nurses were sympathetic and 12% said some were and some were not.

Satisfaction with nursing care in labour and delivery

Ninety per cent of those who had not had elective caesarian sections were satisfied with the attention and treatment they received from nurses during labour and delivery. Ten percent were satisfied with reservations and none were dissatisfied. For the purpose of analysis the group who were satisfied with reservations will be called 'dissatisfied'. They were not significantly younger (26.5 years) than the satisfied group (29.1 years). Ninety-two percent of primiparae were satisfied as against 89.5% of multiparae (NS). 89.7% of the non manual classes were satisfied as against 90.9% of the manual classes (NS). There was a slight negative gradient between satisfaction with nurses in labour and educational status. 95.8% of those with primary education only were satisfied as against 91.5% of those with secondary education and 81.5% of those with third level education (NS).

91.1% of public patients were satisfied with nursing care during labour and delivery compared with 89.1% of private and semi-private patients (NS). 88.8% of mothers from Dublin were satisfied as

against 93.6% of those from rural areas (NS).

There was no association between induction and satisfaction with care from nurses. 91.2% of those induced were satisfied as against 90.1% of those not induced (NS).

90.6% of those monitored n labour were satisfied as against 90.1% of those who were not (NS). There was some relationship between mode of delivery and satisfaction with nursing care. 91.7% of those who had a spontaneous vertex delivery were satisfied compared with 85.7% of those who had had forceps, vacuum or breech delivery and 75% of those who had an emergency caesarian section (NS).

Of the two mothers who were not given their baby to hold immediately after birth one (1) was dissatisfied. Of four who felt they had not held the baby long enough, one was dissatisfied. Of the 141 who held the baby for as long as they wanted only 8.1% were dissatisfied (NS).

89.6% of those offered painkillers were satisfied compared with 88.5% of those who had to ask and 100% of those who neither asked nor were offered anything (NS).

Satisfaction with nursing was associated with satisfaction with pain management in labour (see Table 12).

TABLE 12 SATISFACTION WITH NURSING CARE IN LABOUR IN RELATION TO SATISFACTION WITH PAIN MANAGEMENT IN LABOUR

	Satisfaction with pain management in labour					
Satisfaction with nursing in labour	Satified		Dissatisfied or satisfied with reservations		Pain not bad enough for analgesics	
	No.	%	No.	%	No	%
Satisfied	101	93.5	17	70.8	2	100
Satisfied with reservations	7	6.5	7	29.2	0	
Total	108	100	24	100	2	100

X^2 test (2 d.f.) = 11.04 ($p < 0.0005$)

There was no significant relationship between anxiety levels during labour and delivery and satisfaction with nursing care. 81.8% of those left alone during labour were satisfied with nursing care as against 91.9% of those not left alone (NS). 87.5% of those whose husband was present were satisfied with nursing as against 97.6% of those whose husband was not present (NS).

There was a significant association between mothers feeling that the nurses were sympathetic and their satisfaction with nursing (see Table 13).

TABLE 13 SATISFACTION WITH NURSING CARE IN LABOUR IN RELATION TO WHETHER NURSES WERE FELT TO BE SYMPATHETIC

Satisfaction with nursing in labour	Whether nurses were sympathetic: Sympathetic No.	%	Some were/ Some were not No.	%
Satisfied	126	99.2	5	27.8
Satisfied with reservations	1	0.8	13	72.2
Total	127	100%	18	100%

X^2 test (1 d.f.) 84.22 ($p < 0.0001$)

Satisfaction with care during labour and delivery from doctors

86.4% of those who were attended by a doctor during labour or delivery were satisfied with the care received from the doctor. 9.1% were satisfied with reservations and 4.5% were dissatisfied. For the purposes of this analysis those dissatisfied and satisfied with reservations will be grouped together as 'dissatisfied'.

The satisfied and dissatisisified groups did not differ significantly as regards age. 81.8% of primiparae were satisfied as against 89.4% of multiparae (NS). Eighty per cent of the non-manual classes were satisfied as against 92.7% of the manual classes (NS). Mothers with third level education were less likely to be satisfied than those with primary or secondary education only (see Table 14).

TABLE 14 SATISFACTION WITH DOCTORS DURING LABOUR AND DELIVERY IN RELATION TO EDUCATIONAL STATUS OF MOTHER

Satisfaction with doctor during labour	Educational status (highest)					
	Primary		Secondary		Third level	
	No.	%	No.	%	No.	%
Satisfied	16	88.9	64	92.8	15	65.2
Dissatisfied or satisfied with reservations	2	11.1	5	7.2	8	34.8
Total	18	100	69	100	23	100

x^2 test (2 d.f.) = 11.22 ($p < 0.005$).

89.7% of public patients were satisfied with care received from their doctor during labour as against 81% of private and semi-private patients (NS). There was no difference in the proportion from Dublin who were satisfied (86.5%) compared with the proportion from the country (86.1%) (NS).

68.8% of those left alone during labour were satisfied compared with 89.4% of those not left alone (NS). 86.2% of those saisfied with pain management during labour were satisfied with their doctor as against 90.5% of those who were not satisfied with pain management (NS). There was a strong association between a mother feeling that her doctor was sympathetic and her level of satisfaction with the doctor's care (see Table 15).

TABLE 15 SATISFACTION WITH DOCTOR'S CARE IN LABOUR IN RELATION TO WHETHER DOCTOR WAS FELT TO BE SYMPATHETIC

Satisfaction with doctors in labour	Whether doctors were sympathetic: Sympathetic No.	%	Unsympathetic or some were and some were not No.	%
Satisfied	93	98.9	2	12.5
Dissatisfied or satisfied with reservations	1	1.1	14	87.5
Total	94	100	16	100

x^2 test (1 d.f.) = 79.56 ($p < 0.0001$)

Reasons for satisfaction and dissatisfaction

Mothers were asked whether there was any aspect of their care in labour and delivery with which they were particularly pleased or which they were not happy about. One hundred and twenty-five mothers or 86% of those who experienced labour passed favourable comments. Table 16 gives an indication of the sort of comments made.

TABLE 16 FAVOURABLE COMMENTS ON LABOUR AND DELIVERY CARE

Favourable Comments about:	No. of Mothers	%
Kindness, sympathy of staff	71	56.8
Constant company	41	32.8
Being informed and in control	10	8.0
Treatment	2	1.6
Miscellaneous	1	0.8
Total	125	100

Fifty-five mothers or 37.9% of those who experienced labour passed

unfavourable comments about their experience. The major area of complaint was about the manner of the staff. Other important areas concerned treatment and pain relief (see Table 17).

TABLE 17 CRITICAL COMMENTS ABOUT LABOUR AND DELIVERY CARE

Critical comment about:	No. of Mothers	%
Manner of staff	17	30.9
Treatment	15	27.3
Pain relief	8	14.5
Miscellaneous	6	10.9
Noise, lack of privacy	4	7.3
No doctor in attendance	3	5.5
Change of nursing shift	2	3.6
Total	55	100

POSTNATAL CARE

The major objective of this section was to determine how satisfied mothers were with care on the postnatal ward, but enquiry was also made about health of mother and baby and about feeding.

Fourteen per cent of mothers said that their babies were unwell and 6.7% said they themselves felt unwell. Tables 18 and 19 show the nature of the complaints of mothers and babies who were unwell.

TABLE 18 PROBLEMS OF BABIES WHO WERE UNWELL

Problem	No. of babies	%
Low birth weight, prematurity	4	19.1
Jaundice	8	38.0
Feeding difficulty	1	4.8
Twitching	2	9.5
Fever	2	9.5
Miscellaneous	4	19.1
Total	21	100

TABLE 19 PROBLEMS OF MOTHERS WHO WERE UNWELL

Problem	No. of mothers	%
Painful stiches (perineum)	3	30.0
Pain (caesarian section)	3	30.0
Miscellaneous	4	40.0
Total	10	100

METHOD OF FEEDING

Sixty-two mothers (41.9%) were breast feeding. The remaining 58.1% bottle fed. Two babies were being fed by tube in the special care baby unit and are excluded from this analysis.

Breast feeders were not significantly older than that of bottle feeders - 29.6 years versus 28.3 years. However, primiparae were significantly more likely to breast feed (see table 20).

TABLE 20 RELATIONSHIP BETWEEN METHOD OF FEEDING AND PARITY

Mehod of feeding	Parity: Primiparae No.	Primiparae %	Multiparae No.	Multiparae %
Breast	30	58.8	32	33.0
Bottle	21	41.2	65	67.0
Total	51	100	97	100

x^2 test (1 d.f.) = 8.13 ($p < 0.005$)

There was a strong association between method of feeding and educational status (see Table 21).

TABLE 21 METHOD OF FEEDING IN RELATION TO EDUCATIONAL STATUS

Method of feeding	Educational status (highest): Primary No.	Primary %	Secondary No.	Secondary %	Third Level No.	Third Level %
Breast	4	16.7	37	38.5	21	75.0
Bottle	20	83.3	59	61.5	7	25.0
Total	24	100	96	100	28	100

x^2 test (2 d.f.) = 19.33 ($p = 0.001$).

Private and semi-private patients were significantly more likely to breast feed (see Table 22).

TABLE 22 METHOD OF FEEDING IN RELATION TO PUBLIC/PRIVATE CARE

Method of feeding	Type of care: Public No.	Public %	Private/semi-private No.	Private/semi-private %
Breast	25	27.5	37	64.9
Bottle	66	72.5	20	35.1
Total	91	100	57	100

x^2 test (1 d.f.) = 18.67 ($p<0.0001$)

Breast feeding was also strongly associated with social class (see Table 23).

TABLE 23 METHOD OF FEEDING IN RELATION TO SOCIAL CLASS

Method of Feeding	Social Class: Non Manual No.	%	Manual No.	%
Breast	40	58.8	22	27.5
Bottle	28	41.2	58	72.5
Total	68	100	80	100

χ^2 test (1 d.f.) = 13.56 ($p < 0.0005$)

Dublin mothers were not significantly more likely to breast feed (44.4%) than rural ones (36.7%). Mothers whose husband was present during labour were also more likely to breast feed (see Table 24).

TABLE 24 METHOD OF FEEDING IN RELATION TO PRESENCE OF HUSBAND DURING LABOUR

Method of feeding	Presence of husband: Present No.	%	Absent No.	%
Breast	52	50.5	9	22.0
Bottle	51	49.5	32	78.0
Total	103	100	41	100

χ^2 test (1 d.f.) = 8.65 ($p < 0.005$)

When asked if they had had enough help and support with feeding 88.5% of breast feeders and 89.5% of bottle feeders said yes.

Satisfaction with nursing care on ward

Ninety-six per cent of mothers were satisfied with the attention and

treatment which they received from the nurses on the ward. 3.3% were satisfied with reservations and 0.7% were dissatisfied. The latter two groups will be classified together as 'dissatisfied' for purposes of this analysis.

The dissatisfied group were not significantly younger (26.3 years) than the satisfied group (29 years) (NS). One hundred per cent of primiparae were satisfied as against 93.9% of multiparae (NS). 97.1% of the non manual classes and 95.1% of the manual classes were satisfied (NS). One hundred per cent of mothers with only primary education were satisfied as against 94.8% of those with secondary education and 96.4% of those with third level education (NS). 97.8% of public patients were satisfied as against 93% of private and semi private ones (NS)

There was no significant association between satisfaction with nursing care on the ward and the following variables: induction, mode of delivery, place of residence, method of feeding, health of baby or mother or conflicting advice. This is not surprising in view of the small numbers dissatisfied.

However, bottle feeders who felt that they had not had enough help with feeding their baby were more likely to feel dissatisfied with nursing care on the ward (see Table 2).

TABLE 25 SATISFACTION WITH NURSING CARE ON WARD IN RELATION TO HELP WITH BOTTLE FEEDING

Satisfaction with nursing care	Whether enough help given with feeding: Enough Help No.	%	Not enough help No.	%
Satisfied	75	97.4	6	66.7
Dissatisfied or satisfied with reservations	2	2.6	3	33.3
Total	77	100	9	100

x^2 test (1 d.f.) = 8.86 ($p < 0.005$)

Satisfaction with care on ward from doctors

83.3% of patients were satisfied with the attention received from doctors on the wards. 7.3% were dissatisfied and 7.3% satisfied with reservations. 6.7% had not seen a doctor on the ward by the time of interview. The dissatisfied and satisfied with reservations groups will be grouped together as 'dissatisfied' for the purposes of this analysis.

The satisfied and dissatisfied groups did not differ significantly as regards age. 87.5% of primiparae were satisfied with attention from doctors on the ward as against 90.2% of multiparae (NS). 92.9% of public patients were satisfied compared with 83.6% of private and semi private patients (NS). There was no significant association between satisfaction with attention from doctors on the wards and the following variables: social class, place of residence, induction or method of feeding.

87.5% of those with primary education only were satisfied compared

with 92.1% of those with secondary education and 81.5% of those with third level education (NS).

Ninety per cent of mothers who had a spontaneous vertex delivery, a forceps or vacuum delivey or a breech delivery were satisfied compared with 77.8% of those who had caesarian sections (NS).

Reasons for satisfaction or dissatisfaction

One hundred and ten mothers or 73.3% of the total passed favourable comments about their care on the ward. The vast majority referred to the attention, kindness and sympathy received from the staff (see Table 26). It should be noted that some mothers made both favourable and critical comments.

TABLE 26 FAVOURABLE COMMENTS ABOUT WARD CARE

Favourable comments about:	No. of Mothers	% of Mothers
Attention, kindness, sympathy from staff	91	82.7
Related atmosphere, lack of regimentation	6	5.5
Food	1	0.9
Help with baby	11	10.0
Miscellaneous	1	0.9
Total	110	100

Sixty-nine mothers or 46% of the total passed critical comments about their stay in the ward. The most frequent complaint concerned food (see Table 27).

TABLE 27 CRITICAL COMMENTS ABOUT WARD CARE

Critical comment about:	No. of Mothers	% of Mothers
Food	23	33.3
Lack of time with husband	8	11.6
Noise	9	13.0
Ward organization	7	10.2
Baths/toilets	6	8.7
Excess smoking	4	5.8
Miscellaneous	12	17.4
Total	69	100

ADDITIONAL INFORMATION OF INTEREST

Conflicting advice

Mothers were asked whether they had received any conflicting advice either during the antenatal period or since coming into hospital, from doctors or nurses.

Thirty-nine mothers (26%) did receive conflicting advice. In 51.3% of these cases the advice concerned feeding. The most common area of conflict concerned breast feeding. There appeared to be very little agreement among staff on whether demand feeding or timed feeding was correct. 28.2% of cases of conflicting advice concerned the treatment of the mother herself and 10.3% concerned aspects of baby management other than feeding. Another 10.3% of cases received miscellaneous items of conflicting advice. In 76.9% of cases of conflicting advice, the advice of two nurses was conflicting. In

12.8% two doctors gave the advice and in 10.3% it was a doctor and a nurse.

Home birth and willingness to return to hospital

It was felt that willingness to return to the hospital for a further birth might serve as a useful indicator of satisfaction. Thus, mothers were asked whether, in the event of another pregnancy they would prefer to come back to the Coombe, go to another hospital or have the baby at home.

One hundred and thirty-eight mothers (92%) expressed themselves willing to come back, 9 favoured home birth (6%) and 2% (3 patients) said that they would go to another hospital. When asked why they would not come back to the Coombe, 6 out of the 12 not wishing to return said they would like to give birth in the familiar environment of their own home, one felt the increased mobility at home would be an advantage and one liked the idea of having her family around her. One said she would go elsewhere just for a change of scene. Three complained of being badly treated on this pregnancy. All three had had emergency caesarian sections. One was a primiparous semi-private patient aged 25. The second was a public patient, para 1 and aged 24. The third was a private patient, para 2 and aged 27.

Those who favoured home birth were asked whether they would still opt for birth at home even if it meant a slightly increased risk to the baby's life or health. All nine said that if that were the case they would prefer to come to hospital for the birth.

Midwife clinics

Mothers were asked whether they would prefer to be looked after by a doctor or by a midwife for their antenatal care, providing all was going normally, and provided that a doctor would see them at once should a problem develop.

Seventy-one mothers, 47.3% said they would prefer a doctor, 41 (27.3%) a midwife and 38 (25.3%) would not mind which.

Significantly more multiparae favoured a doctor (see Table 28).

TABLE 28 PREFERENCE FOR DOCTOR/MIDWIFE ANTENATAL CARE IN RELATION TO PARITY

Preference	Parity			
	Primiparae		Multiparae	
	No.	%	No.	%
Doctor	21	50.0	50	71.4
Midwife	21	50.0	20	28.6
Total	42	100	70	100

x^2 test (1 d.f.) = 4.31 ($p < 0.05$)

Almost half of the public patients who expressed a preference would prefer a midwife. Private and semi-private patients were more likely to favour a doctor (see Table 29).

TABLE 29 PREFERENCE FOR DOCTOR/MIDWIFE ANTENATAL CARE IN RELATION TO WHETHER PATIENT WAS PUBLIC OR PRIVATE

Preference	Type of Care: Public No.	Public %	Private No.	Private %
Doctor	35	52.2	36	80.0
Midwife	32	47.8	9	20.0
Total	67	100	45	100

x^2 test (1 d.f.) = 7.78 ($p < 0.01$)

61.8% of the non-manual classes preferred a doctor as against 64.9% of the manual classes (NS). 48.8% of those who were dissatisfied with antenatal care preferred a midwife as against 29.6% of those who were satisfied (NS).

Male or female doctors

Mothers were asked whether they would prefer to be cared for by a male or a female doctor if given the choice. Seventy-two mothers (48%) would not mind which, 43 (28.7%) would prefer a male and 35 (23.3%) would prefer a female.

Length of stay

34.7% of mothers felt that the length of stay in the wards after delivery was too long. Sixty-two per cent felt it was about right and 3.3% felt it was too short.

Overall satisfaction

As mentioned in the section on methods, a new variable was computed in

order to give some sort of overall indication of satisfaction. The scale developed ranged from 0 to 100 and the frequency distribution of the various scores is shown in Table 30. The mean score for the sample was 90.7, with a median of 93.1. The minimum value was 37.5 with a maximum of 100 and a range of 62.5. One-third of cases scored less than 86.

TABLE 30 SATISFACTION SCORE FREQUENCY DISTRIBUTION

Score	Absolute Frequency	Relative Frequency	Cumulative Frequency
38	1	0.7%	0.7%
43	1	0.7%	1.3%
50	1	0.7%	2.0%
63	1	0.7%	2.7%
64	5	3.3%	6.0%
67	2	1.3%	7.3%
71	3	2.0%	9.3%
75	5	3.3%	12.7%
79	5	3.3%	16.0%
80	1	0.7%	16.7%
83	5	3.3%	20.0%
85	20	13.3%	33.3%
88	1	0.7%	34.0%
90	1	0.7%	34.7%
92	6	4.0%	38.7%
93	23	15.3%	54.0%
100	69	46.0%	100.0%
Total	150	100.0%	

The relationship between the satisfaction score and the quantitative variables, age of mother, gestation at time of first visit and length of time waiting at the clinic was examined. No significant correlation was found.

Any case scoring less than 100 must have given at least one critical answer to one of the 7 key questions. This group could be regarded as being "critical overall". Thus, we have a very sensitive but probably not very specific index of overall satisfaction similar to

that constructed by Dunt and LeMaine Parker in the Australian/Greek migrant study (29).

The relationship between those scoring 100 and those scoring less than 100 and a number of variables was examined. 57.7% of primiparae were critical overall as against 52% of multiparae (NS). Forty-eight per cent of mothers with only primary education were critical overall as against 50.5% of those with secondary education and 71.4% of those with third level education (NS). 54.8% of public patients were critical overall as against 52.6% of private and semi private patients (NS).

As regards social class, the proportions critical overall are shown in Table 31.

TABLE 31 PROPORTION OF MOTHERS "CRITICAL OVERALL" IN THE VARIOUS SOCIAL CLASSES

Social class	% Critical Overall
I	45.5
II	75.0
III non manual	52.4
III manual	50.0
IV	56.5
V	50.0

Sixty per cent of Dublin residents were critical overall as against 42% of rural residents (NS).

As regards mode of delivery, 52.5% of those delivering normally were critical overall as against 57.1% of those delivered by forceps, 33.3% of breech deliveries, 100% of vaccuum deliveries, 25% of elective section deliveries and 80% of emergency section deliveries (NS). 56.5% of breast feeders were critical overall as against 51.2% of bottle feeders (NS).

DISCUSSION

The main reason for carrying out this study was to find out how satisfied women are with maternity care and to identify the aspects of care giving rise to dissatisfaction and the reasons for such dissatisfaction. It quickly emerged that the main problem area was antenatal care.

ANTENATAL CARE

One third of mothers in this study were dissatisfied with or had reservations about antenatal care. This may be compared with 16% in Kirke's study of two London hospitals (4% in one, 28% in the second) (25). Sullivan's study in Arizona found 7% of mothers dissatisfied (32). A lower proportion of mothers were primagravidae in the present study (34.7%) than in Kirke's (46%) or Sullivan's (44%) studies, but satisfaction was not related to parity. The Consumer Association in the United Kingdom found 14% dissatisfied (23). The higher level of dissatisfaction in the present study may relate to the fact that the Coombe hospital delivers far more patients per year than any of the units in the other studies, but undoubtedly there is cause for concern about this finding.

While there has been some criticism of workers who seek explanations for non-attendance at clinics in the characteristics of the mothers

themselves (56). It would seem reasonable to look at patient characteristics when doing a user-orientated study in order to identify sub-groups whose needs and wishes may not be well catered for by the service under scrutiny. Thus, satisfaction with different aspects of care has been examined in relation to various patient characteristics in this study.

The most important finding to emerge from this analysis was the fact that public patients were much more often dissatisfied with antenatal care than private and semi-private ones. While this may not come as much surprise to those who have attended or worked in any of the busy antenatal clinics of Dublin's major maternity units, it is surely useful to have some quantification of the size of the problem should any organizational changes be contemplated.

Possession of Voluntary Health Insurance was, as might be expected associated with significantly higher satisfaction levels but surprisingly possession of a medical card had no such effect. While the manual classes were not significantly more likely to be dissatisfied than the non-manual, it is interesting to see that satisfaction was considerably higher in social classes I and V than in the intermediate classes. This finding is somewhat similar to Kirke's (25). Cartwright has suggested that expectations among the lowest social class patients may be less than among the middle classes (7). A similar but non-significant trend emerged in relation to education. Satisfaction levels were higher among those with primary or third level education than among those with only secondary schooling.

While parity had little effect on satisfaction with antenatal care, dissatisfied patients were significantly younger than satisfied ones. Cartwright has reported similar age trends among general hospital patients (7). While each of these associations may be of interest, undoubtedly the most important finding is the strong association of dissatisfaction with public rather than private care. It is of considerable importance that two-thirds of the dissatisfied group complained of being rushed at the clinic and not getting enough informationabout themselves or their babies (Table 11). The decision to examine doctor-patient communication in the antenatal clinic seems to have been appropriate as the likelihood of adequate communication occurring easily in a rushed, crowded situation was small.

However, not only did public patients complain more of being rushed at the clinic, but they had to wait a considerably longer time than private patients to be seen, although not much longer than semi-private patients. Surprisingly the number complaining of waiting too long in response to the open question on antenatal care was relatively small. Studies elsewhere have shown similar waiting times at various hospitals, and it has been suggested that if patients were almost always seen within 30 minutes of their scheduled time, patient satisfaction would increase sharply (57).

Communication in the antenatal clinic

There were 4 questions in the antenatal section of the questionnaire concerned directly with communication. Only two-thirds of patients found out all they wanted at the clinics despite the fact that 80% asked questions. Nearly half felt there was insufficient opportunity

to ask questions and in only half of the cases was it usual for the doctor to volunteer information.

These results may be compared with those of other studies. In a study of teaching hospital patients in Vermont, one quarter of patients were unable to find out as much as they wanted (11). In Cartwrights 1965 study only one third of multiparous mothers and less than a fifth of primagravidae had no difficulty with communication (7). Kirke's study, however, was the one most comparable with the present study as regards questions on communication (25). Twenty per cent of patients in one of his hospitals and 40% in the other were unable to find out all they wanted about their pregnancy. Ten per cent in one hospital and 40% in the other felt that they had insufficient opportunity to ask questions and in 40% of cases doctors did not volunteer information. Thus, it is clear that the communication problems of mothers in the present study are at least as serious as those in previous surveys, and maybe slightly worse.

However, it is clear that public patients in this study fared considerbly worse than any of the patients in other studies, and significantly worse than private patients on all indices of communication. As already discussed dissatisfaction was strongly associated with being a public patient, and as may be seen in Tables 5, 6, 7 and 8, with communication difficulties. Thus, all the evidence so far points to the fact that many more public patients are unhappy with their antenatal care and that much of this discontent relates to them not obtaining enough information about themselves or their babies.

Antenatal classes

The attendance at antenatal classes of the primagravidae in this study compared well with other studies. Fifty-eight per cent of primagravidae in Kirke's (25) and 42% in Reid and McIlwaine's study (56) attended, whereas 81% attended in this study. A small number of public patients mentioned that they felt out of place at the classes as they had little in common with middle class private patients whose discussion was frequently concerned with topics such as holidays in exotic parts of the world. These public patients also said that they felt self-conscious when comparing their own clothes with the expensive dresses of the private cases. Eighty-five per cent of mothers said the classes helped "a lot" or a "fair bit" which was somewhat better in Kirke's study (25).

It would seem reasonable to do some market research among non-attenders and those who do not find existing classes helpful with a view to identifying the areas which are of most interest to them. In view of the volume of favourable comment from those who do attend there would seem to be little point in changing the existing class arrangements or content for those who do attend but perhaps a smaller number of somewhat different classes aimed specifically at the mothers who do not attend at present may be worth considering. While the concept of separate classes for public and private patients may seem discriminatory perhaps if the two different types of classes were explained to mothers they could then choose the one most appropriate for themselves.

Combined antenatal care

A somewhat higher proportion of patients found out all they wanted to know from their G.P. than was the case in the hospital clinic.

Women having combined care did not have to wait as long to be seen and presumably usually spent less time travelling. Part of the reason why waiting time was less was that these women could visit their G.P. at a time when they knew that few others would be at the surgery.

It is surprising that only 47% preferred the G.P. aspect of care. Some mothers said that despite the greater inconvenience of the hospital antenatal clinics, they felt happier being seen by the obstetrician as they thought that being specialized in maternity work he would be less likely to miss things and might provide better medical treatment should complications occur.

These findings are fairly similar to those of another study in which 2,000 randomly selected mothers in the United Kingdom were asked about their experience of maternity care (SH). Sixty-one per cent said that the G.P. was very good at explaining things, whereas only 45% felt the hospital doctor was. However, 71% rated their G.P. very good on medical and nursing care compared with 63% who felt the hospital was very good for these aspects of care. This is not quite the same as asking them did they prefer G.P. or hospital care but it suggests a somewhat greater preference for G.P. care than was found in the present study.

LABOUR AND DELIVERY

Although it was clear that antenatal care was a major problem area for many mothers, it became equally clear that satisfaction with other aspects of care, particularly care during labour and delivery was very high. It is important to remember that unmarried mothers, and those with stillbirths or whose babies had major malformations were excluded. Thus, we are discussing the views of a group of mothers, most of whom delivered healthy babies and who presumably had support from their husbands. We have no indication of the feelings of the other groups mentioned above.

Ninety per cent of mothers were satisfied with nursing care and 86% with medical care but only 78% with management of pain. These figures compare favourably with Kirke's findings (25). Seventy-seven per cent of his respondents were satisfied with nursing care during labour and delivery and 73.8% with care from doctors. However, 24% of mothers in the present study claimed not to have been seen by a doctor during labour and delivery as against 15% in Kirke's study. In Cartwright's 1964 study only 46% of mothers were entirely enthusiastic about nursing care in labour (7). Twenty per cent of patients in Climie's study in Australia recalled disappointing features of their care in labour and delivery but 95.8% felt that the staff in the labour ward were generally 'very helpful' or 'helpful' (24). Thus, general satisfaction with nursing and medical care during labour in the present study compares favourably with previous work. However, while 86% of mothers who experienced labour passed favourable comments, 38% passed critical ones about their experience. These were mainly concerned with staff manner, treatment received or

management of pain. Climie notes similar discrepancies between open and closed questions and suggests that perhaps the general complaints need not all be taken too seriously. There may be some truth in this idea as six out of the 14 mothers who expressed reservations about nursing care and 13 out of 15 with reservations about medical care also expressed favourable comments on their experiences.

Virtually identical proportions of public patients (91.1%) and private patients (89.1%) were satisfied with nursing care. This would tend to contradict the argument that working-class and middle class people have different expectations and that these satisfaction levels will reflect these differences (7). In other words, in this particular aspect of care, where public and private patients experience virtually identical care they have very similar satisfaction levels. Therefore, it seems reasonable to suggest that when their satisfaction levels differ they are experiencing true differences in service as in the antenatal situation.

The most important factor associated with satisfaction was the mothers' perception of whether or not the doctors and nurses were sympathetic. Kirke found very similar results and commented that if patient satisfaction was related more to the psychological and social aspects of the doctor patient relationship than to the technical aspects of care (25).

An example of the sort of comments passed by mothers dissatisfied with care received from doctors is as follows: "I was scared during the breaking of the waters. I did my best but after it the doctor said 'You made that worse than it was.' I felt terrible - I was made to

feel a complainer." This comment was made by a 22 year old primipara.

Another 22 year old primipara said: "The doctor was laughing and joking with the nurses while he was putting the clip on the baby's head. He explained nothing."

Pain Relief In Labour

Roughly a fifth of mothers who had inhalational analgesia or pethilorfan were dissatisfied with the way their pain was managed, whereas a surprisingly high percentage of the eight mothers who had epidural analgesia were dissatisfied. Overall 18.2% were not satisfied with how their pain was managed. This is similar to the figure of 12.4% which Climie found in his study in Australia (24).

It is interesting to review the results of Morgan's study in Queen Charlottes Maternity Hospital at this point (33). Only 50% of mothers considered epidural analgesia the best form of pain relief in labour - this figure is very much in accordance with our own results. Secondly, Morgan notes that the traditional role of the midwife in providing emotional support was more valued by mothers than were all forms of pain relief. Again this is in keeping with our own finding that satisfaction with pain relief in labour is significantly associated with satisfaction with nursing care in labour (Table 12).

Procedures during labour and delivery

While the major objective of this study was not to investigate medical

interventions and procedures used during labour, some of the findings in this area are worthy of brief comment.

On the question of induction, the rate was similar to that found by Cartwright in her 1975 study in the U.K. (44). As noted earlier the Coombe Hospital has a higher induction rate than either of the other major units in Dublin. In the vast majority of cases an explanation of why she was being induced was given to the mother without her having to ask. These figures were very similar to Kirke's (25). However, a small percentage seem not to have received an explanation, one of whom had asked for it.

Communication about reasons for monitoring the fetal heart seems to have been rather less complete with 17% neither asking for nor receiving an explanation. However, this figure was considerably better than the 51.5% who had received no explanation in Kirke's study (25). Fetal monitoring is still a fairly inexact science with relatively poor sensitivity and specificity, (59) but threequarters of the mothers in the Coombe study felt more secure because of it. Similar findings have been reported elsewhere (60), but complacency is not indicated as fetal monitoring may cause a higher caesarian section rate and may have psychological or emotional risks in certain cases (61).

Communication about the reasons for instrumental delivery was better in this study than in Kirke's (25) but it is important to note that dissatisfaction was considerably more prominent among those who had instrumental deliveries, especially emergency caesarian sections. Clearly mothers likely to end up with an emergency caesarian section

should be handled with as much sensitivity as possible. One young primagravid girl, a member of the travelling comminity, felt particularly anxious when informed that she would have to be "sectioned". She was clutching a number of religious relics in her hand all during the labour, but as she was been given a general anaesthetic prior to surgery she heard a dotor say somewhat roughly "get rid of all that junk".

Position at Birth

The traditional dorsal position for labour and birth is a relatively recent innovation but there is some evidence that the upright position and the lateral position improve the quality of uterine contractions (62). Although 85% of mothers in the Coombe study delivered in the dorsal position and only 13.3% on the recently introduced delivery chair, it is of interest that 25.2% said they would choose the chair for a future occasion. Also the outcome of a study comparing the efficacy and acceptability of the delivery chair among primigravidae at the Coombe is awaited with considerable interest.

Company during Labour

15.2% of mothers were left alone in labour compared with 43% in Kirke's study (25) and 60% in Cartwright's 1964 study (7). In contrast to these earlier studies mothers left alone were not more likely to be dissatisfied with nursing care, probably because they were never alone for more than a few moments.

Presence of husband during labour

Fifty-two per cent of mothers had their husband present with them during labour. This is higher than in previous studies - Kirke - 49% (25), Cartwright (1964) - 19% (7), and Climie (1973) - 30% (24). Hospital policy did not seem to provide any barrier to the presence of husbands. Climie also noted that the presence of husbands was a frequent cause of friction (24). Perhaps this is an area requiring some further study.

Postnatal Care

Satisfaction with postnatal nursing care was higher than with any other aspect of care - (96%). So few were dissatisfied with this aspect of care that it is difficult to draw any firm conclusions (5 were satisfied with reservations and one dissatisfied).

Although there is some evidence that patients are more critical of their care if interviewed while still in hospital instead of following discharge (63), others have felt that patients are more likely to express their true feelings when interviewed at home (64). However, during the course of this study the relationship between patients and ward nursing staff certainly appeared excellent and thus it is concluded that our results are probably reasonably valid.

In view of the small numbers dissatisfied there is little point in drawing major conclusions about the influence of maternal characteristics on satisfaction with nursing care on the ward. However, it is interesting to note that public patients were not more

dissatisfied than private patients with nursing care despite the fact that they are accommodated in larger wards.

Satisfaction with care from doctors on the ward was considerably less than with nursing care (83.3%). 6.7% had not been seen by a doctor on the ward by the time of interview but it should be noted that a bank holiday weekend occurred during the study and during this period there was only a skeleton medical staff on duty. It is notable that criticisms of ward care referred more to items such as food and noise rather than to manner of staff.

Several mothers commented on the lack of regimentation on the wards, especially multiparae who may have experienced a harsher regime in the past. However, 10% of critical comments concerned ward organization. Early waking and lack of opportunity to rest were particularly strong complaints, and while being aware of nursing constraints one wonders whether there is not some means by which hospital patients could be allowed sleep on after 6 a.m. should they wish to do so.

Another area of discontent concerned lack of time to be alone with and talk to husbands without other visitors being present. A number of mothers found this very frustrating. Perhaps there should be a special visiting time for husbands alone. This problem has been noted in other studies (31).

Several mothers complained of the fact that visitors and other mothers smoked in the wards and they felt that this was bad for the babies. Although notices forbidding smoking were displayed they were neither obeyed nor enforced, but they should be.

However, other mothers complained of not being allowed smoke in the wards and of having to go down to the day-rooms if they wanted a cigarette. Several mothers were angry with staff who stopped them from smoking on the wards. Interestingly it was not the nurses who provoked this annoyance. They were felt to be quite "understanding". Instead it was the domestic staff who had stopped mothers smoking and were therefore a target for considerable anger. It is interesting to think that the non-professional hospital staff may have adhered more closely to principles of preventive medicine than the professionals in this instance.

These sort of findings confirm the importance of the comment made by Houston et al (11) who feel that there is a limit to how much satisfaction can be obtained. This is especially likely when mothers themselves have conflicting wishes.

Feeding

The proportion of mothers breast feeding (41.9%) was lower than in Kirke's (25) study (46%) but considerably higher than in the National Survey of Infant feeding practices in Ireland carried out in 1981 which found 32% of mothers were breast feeding at discharge (65). The association of breast feeding with first baby, greater education, non-manual social class, residence in the city and private patient status was similar in the Coombe study and the 1981 Irish study. While the relatively high proportion of mothers of the Coombe choosing to breast feed is gratifying it is unfortunate that it is the more disadvantaged who, as in the other studies, seem to avail least of

what is generally accepted as the optimum method of infant feeding.

ADDITIONAL INFORMATION

Conflicting Advice

The fact that one quarter of the mothers in the study received conflicting advice is cause for concern. As this frequently involved the important area of breast feeding there is clearly a need for the nursing staff to reach a sort of consensus and to adopt a common approach to this question. Similar complaints about conflicting advice have been found in other studies (31).

Midwife Clinics

The finding that more than a quarter of mothers would prefer a midwife for antenatal care is of considerable importance. The fact that it is the dissatisfied group and the public patients who have a stronger preference is also important. Clearly the introduction of a midwife antenatal programme should receive serious consideration as a measure to improve what is the major area of dissatisfaction found in this study - namely, the public antenatal clinic. This would be very much in accordance with the recent recommendations of the British Maternity Services Advisory Committee. In its report the Committee states:

> "Midwives are trained to give care and advice throughout pregnancy, including the detection of abnormal conditions and their referral for medical advice where appropriate. Neglecting to use these skills, or their ineffective use, results in low job satisfaction for midwives, wastes financial and manpower resources, and ultimately leads to a poorer service to pregnant women." (60)

Male or female doctors?

A question on mothers preferences for male or female doctors was included as it was thought that some mothers might feel that another woman would be the best person to understand, explain and provide assistance for an event which men cannot experience. Half of the mothers took what seemed very reasonable approaches to this question. They said that they would not mind whether their doctor was a man or a woman provided he or she was good at the job and was kind and sympathetic. The remaining 50% of mothers were roughly equally divided between those who preferred a male and those who preferred a female. Of course, it must be remembered that female obstetricians are uncommon in Ireland and few women have had the opportunity to experience both male and female ones. In view of the fact that 25% of mothers would prefer a female doctor there is a good case to be made for encouraging more female doctors to train in obstetrics. Also it has been shown elsewhere that male medical students are more likely to have a negative and stereotyped attitude towards women than female students (67).

Home birth and willingness to return to hospital

The proportion of mothers willing to return to the Coombe (92%) was considerably higher than Kirke's figure of 77% (25) and similar to the figure found by Raphael in 1974 (63). In fact, the Coombe figure may be higher still as, with hindsight, the question used in the present study might have been split into two with advantage. Mothers were

asked "If you were to have another baby, and if you could choose where to go for the birth would you prefer to come back here, go to another hospital or have a home birth?" This question actually contains several ideas which would be better separated. Only three patients wished to go to another hospital, whereas most of those favouring home birth had not had a bad experience in hospital but in fact perceived distinct advantages in home birth.

However, it is important to note that the three who would not come back because they were unhappy about their treatment or attention all had had emergency sections. Clearly mothers likely to end up being sectioned as an emergency should be treated with special sensitivity.

The finding that mothers favouring home birth would not insist on it if the risk to the baby was increased by so doing is important. Although the debate on whether or not home births carry an additional risk continues, the fact that intrapartum complications requiring emergency caesarian section are not always predictable would make it surprising if home births were found not to be more dangerous than hospital births. Whatever the outcome of this controversy, women in this study have shown themselves to be responsible when it comes to the welfare of their unborn child. Their view on this point of risk to the baby differs from that of members of an organisation in Ireland which advocates home birth (69).

Length of Stay

The finding that one third of mothers felt that duration of stay in hospital after delivery was too long suggests that a policy of early

discharge for suitable patients who wish it should be considered. Possibly an arrangement such as the British Domino system might be suitable. This refers to the DOMiciliary midwife IN and Out system which means that antenatal and postnatal care are given in the home by a midwife but she takes the mother to hospital for the delivery itself. However, adequate support facilities in the community would be necessary if this were to be introduced here.

Overall Satisfaction

The satisfaction score devised was a somewhat arbitrary measure and it failed to demonstrate any significant trends, although a number of non-significant one's were apparent. Interpretation of the findings is even more arbitrary. On one hand, the mean score for the sample was 90.7% and one could claim that the mothers were 90% satisfied with the service. On the other hand 54% scored less than 100 and one could claim that over half the mothers were critical overall. In some ways this would be a reasonable summing up of the findings of the study as a whole. The main problem area highlighted by the satisfaction score is that of instrumental deliveries, especially emergency sections. This would agree with earlier findings and is clearly an area for concern. However, the usefulness of the satisfaction score seems limited and it is much better to concentrate on the results of the various subsections of the study in order to get a grasp of where the real problems with the maternity services lie, at least for the users.

CONCLUSIONS

This study was undertaken in order to obtain an assessment of patient satisfaction with maternity care as provided through an Irish maternity hospital. The findings apply to the Coombe hospital and it cannot be assumed that they are representative of other maternity units.

Antenatal care was the area giving rise to most dissatisfaction, and it was the public patient who were most dissatisfied. It was clear that a long wait followed by only brief contact with the doctor and poor communication caused considerable discontent among these mothers.

Waiting time was somewhat less when mothers attended their G.P. under the combined antenatal care scheme, but communication remained a problem and less than half of the mothers in the scheme preferred G.P. care. A considerable proportion of mothers would prefer a midwife to give them antenatal care. There would seem to be a case to be made for encouraging the development of a midwife antenatal programme at the Coombe. This would have the effect of reducing pressure on the hospital antenatal clinic and would allow hospital doctors to devote more time to each patient. Greater attention should be paid to doctor-patient communication in medical schools and in post-graduate training programmes. The goal of a maximum waiting time of 30 minutes should be set for the antenatal clinics.

Satisfaction with care during labour and delivery was considerably better than with antenatal care. Nursing care produced a particularly favourable response from both public and private

patients. However, the manner in which medical staff approach their patients in the labour ward appears to require some attention. Particular sensitivity is needed when dealing with patients requiring instrumental delivery, especially emergency section. There was some dissatisfaction with management of pain in labour but many mothers seemed prepared to expect to bear a considerable amount of pain and there was is evidence that the level of sympathetic care from attendants may have more bearing on satisfaction than the use of any particular method of analgesia. Explanation of procedures used during labour and delivery seemed fairly complete.

Satisfaction with nursing care on the wards was very high but there was a considerable problem of mothers receiving conflicting advice from nurses in relation to breast feeding. Clearly there is need for better co-ordination in this area. A substantial number of mothers favoured early discharge, and the feasibility of shortening length of stay should receive attention. This would require development of more community services.

Overall satisfaction with care was high and most mothers said they would return to the same hospital for a future birth. However, a small number of mothers felt that they had been treated so badly that they would not return. It would seem that a system of checking on the number of mothers who feel this way, and identifying the reasons why they would not return might be a useful way of monitoring patient dissatisfaction on a continuing basis.

Although little work has been done in the field of patient satisfaction with obstetric care in Ireland, elsewhere this type of

study is regarded as an important aspect of evaluating a service. It is hoped that its findings will lead to improved patient care in the hospital concerned and that it may stimulate other medical institutions to similar evaluations.

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APPENDIX I

CONFIDENTIAL

OFFICE USE ONLY

SURVEY NO. [ ][ ][ ] I-3

[I] 4 card no.

MATERNITY SERVICES

CONSUMER SATISFACTION QUESTIONNAIRE

PART I - ANTENATAL CARE.

QI Have you had any other children or is this your first? (first baby = para 0) [ ][ ] 5-6

Q2 Is the baby a boy or a girl?

boy	I	
girl	2	[ ] 7

Q3 Where did you go for antenatal care during your pregnancy?

Hospital clinic (public)	I	
Hospital clinic (semi private)	2	
Obstetrician (private)	3	
Health Board clinic	4	[ ] 8

Q4 Did you avail of the combined care scheme?

yes	I	
no	2	[ ] 9

Q5 How many weeks were you pregnant when you went for your first antenatal visit? (excluding the first visit to your GP to confirm that you were pregnant) [ ][ ] IO-II

Q6 How long did your antenatal check-ups at the hospital (health centre) usually take, including the time you spent waiting to be seen by the doctor? (answer in minutes) [ ][ ][ ] I2-

Q7 (If in combined scheme) What about the check-ups with your GP - how long did they usually take? [ ][ ][ ] I5-1

Q8 Did you miss any of the appointments for your antenatal check-ups, and if so how many?

none missed	I	
missed I	2	
missed 2-3	3	
missed more than 3	4	☐ I8

Q9 During your antenatal check-ups at the hospital (health centre) did you ask the doctor(s) any questions?

yes	I	
no	2	☐ I9

QIO (If in combined scheme) What about the check-ups with your GP - did you ask him any questions?

yes	I	
no	2	☐ 20

QII During your antenatal check-ups at the hospital (health centre) did the doctor(s) explain things without you having to ask?

usually	I	
rarely	2	
never	3	
no need for explanation, patient knew enough	4	☐ 2I

QI2 (If in combined scheme) What about the check-ups with your GP - did he explain things without you having to ask?

usually	I	
rarely	2	
never	3	
attended hospital/health centre only	8	☐ 22

Q13 Were you able to find out all you wanted about your pregnancy during the antenatal visits to the hospital (health centre)?	yes	1	
	no	2	☐ 23
Q14 (If in combined scheme) What about the check-ups with your GP - were you able to find out all you wanted about your pregnancy during these?	yes	1	
	no	2	
	attended hospital/health centre only	8	☐ 24
Q15 Do you think you had enough opportunity to ask questions at your antenatal check-ups at the hospital (health centre)?	yes	1	
	no	2	☐ 25
Q16 (If in combined scheme) What about the check-ups with your GP - do you think you had enough opportunity to ask questions at these?	yes	1	
	no	2	
	attended hospital/health centre only	8	☐ 26
Q17 How many antenatal classes did you attend?			☐ 27
Q18 Did you attend the refresher class? (multips only)	yes	1	
	no	2	
	primip	3	☐ 28

Q19 (If attended classes) Did the class(es) help?

a lot	I	
a fair bit	2	
not much	3	
no classes	4	☐ 29

Q20 Was there anything about your antenatal care which you felt was particularly good? ☐ 30

Q2I Was there anything about your antenatal care which you weren't happy about? ☐ 3I

Q22 Generally speaking were you satisfied or dissatisfied with your antenatal care?

satisfied	I	
dissatisfied	2	
satisfied with reservations	3	☐ 36

Q23 (If combined care) Which did you prefer- the GP check-ups or those done at the hospital (health centre)?

GP	I	
Hospital/health centre	2	
no preference	3	
not in combined care	8	☐ 37

PART II - LABOUR AND DELIVERY

Q24 Did you go into labour yourself or were you started off by the doctor?

started herself	1	
induced	2	
elective LSCS	8	→ 41

Q25 (If induced) Did you ask why you were being started off or did the staff explain without you having to ask?

patient asked, staff explained	1	
patient asked, staff didn't explain	2	
patient didn't ask, staff explained	3	
patient didn't ask, staff didn't explain	4	
not induced	8	→ 42

Q26 Do you know if your baby's heart was recorded by a machine during labour?

yes	1	
no	2	
elective LSCS	8	→ 43

Q27 (If monitored) Did you ask why this was done or did the staff explain without you having to ask?

patient asked, staff explained	1	
patient asked, staff didn't explain	2	
patient didn't ask, staff explained	3	
patient didn't ask, staff didn't explain	4	
not monitored	8	→ 44

Q28 Knowing that your baby's heart beat was being recorded, did this make you feel more safe and secure or less safe and secure than if it had not been done?

more secure	I	
less secure	2	
neither more nor less secure	3	
not monitored	8	☐ 45

Q29 Did the doctor use a forceps to deliver the baby or did you deliver him/her yourself?

spontaneous vertex delivery	I	
forceps	2	
breech	3	
vaccuum	4	
LSCS (elective)	5	
LSCS (emergency)	6	☐ 46

Q30 (If delivery instrumental) Did you ask why this was necessary or did the staff explain without you having to ask?

patient asked, staff explained	I	
patient asked, staff didn't explain	2	
patient didn't ask, staff explained	3	
patient didn't ask, staff didn't explain	4	
delivery <u>not</u> instrumental	8	☐ 47

Q3I (If delivery <u>not</u> instrumental) Did you deliver the baby lying on your back or on your side?

side	I	
back	2	
birth chair	3	
instrumental delivery	8	☐ 48

Q32 Were you satisfied with this or would you have preferred a different position?

satisfied	1
prefer side	2
" back	3
" squatting	4
" birth chair	5
instrumental delivery	8

49

Q33 Did you hold the baby straight away after he/she was born, while you were still in the delivery room? If yes, were you able to hold him/her as long as you wanted or did they take him/her earlier or leave him/her longer than you wanted?

no, didn't hold baby in delivery room	1
held baby - but not long enough	2
held baby as long as wanted	3
held baby - but left too long	4
couldn't hold baby (LSCS etc.)	8

50

PAIN RELIEF IN LABOUR

Q34 Before you went into labour did you intend to have a "natural birth" without any artificial pain killers?

definitely no pain killers	1
no pain killers unless pain bad	2
intended to have pain killers	3
no definite plan	4
elective LSCS planned	8

51

Q35 During labour did you ask for anything to relieve pain or did the staff offer you something without you having to ask?

staff offered	1
patient asked	2
neither	3
can't remember	4
labour too advanced by admission	5
elective LSCS	8

52

Q36 During your labour were you given anything at all to relieve pain, before the actual delivery?

(a) Pethidine:	yes	1
	no	2
	not relevant	8 → 53
(b) Gas:	yes	1
	no	2
	not relevant	8 → 54
(c) Epidural:	yes	1
	no	2
	not relevant	8 → 55

Q37 Were you satisfied or dissatisfied with the way your pain was relieved during labour?

satisfied	1
satisfied with reservations	2
dissatisfied	3
pain not bad enough to require anything	4
labour too advanced by admission	5
elective LSCS	8 ☐ 57

Q38 During labour did you feel quite calm or were you anxious?

calm	1
slightly anxious	2
very anxious	3
elective LSCS	8 ☐ 58

Q39 During the delivery did you feel quite calm or were you anxious?

calm	1
slightly anxious	2
very anxious	3
elective LSCS	8 ☐ 59

COMPANY IN LABOUR

Q40 Were you left alone at all during labour or delivery?

yes	1	
no	2	
elective LSCS	8	60

Q41 Was your husband with you during labour and delivery?

yes	1	
labour only	2	
delivery only	3	
neither	4	
elective LSCS	8	61

Q42 (If husband <u>not</u> there during labour or delivery) Why was he not there all the time?

patient didn't want it	1	
husband didn't want it	2	
husband couldn't make it	3	
hospital wouldn't allow it	4	
elective LSCS	5	
husband there for both	8	62

Q43 In general did you find the doctors sympathetic and understanding towards you during labour and delivery?

yes	1	
no	2	
some were, some weren't	3	
no doctor present	4	
elective LSCS	8	63

Q44 In general did you find the nurses sympathetic and understanding towards you during labour and delivery?

yes — I
no — 2
some were, some weren't — 3
elective LSCS — 8 ☐ 64

Q45 Was there any aspect of your care in labour which you felt was particularly good? ☐ 65

Q46 Was there any aspect of your care during labour and delivery which you weren't happy about? ☐ 66

Q47 Are you satisfied with the attention and treatment you were given during labour and delivery by the nurses or do you think it could have been better?

satisfied — I
satisfied with reservations — 2
dissatisfied — 3
elective LSCS — 8 ☐ 71

Q48 Are you satisfied with the attention and treatment you were given during labour and delivery by the doctors or do you think it could have been better?

satisfied	1	
satisfied with reservations	2	
dissatisfied	3	
didn't see a doctor	4	
elective LSCS	8	☐ 72

PART III - BABY AND POSTNATAL CARE

SURVEY NO. ☐☐☐ I-3

☐2 4 card no.

Q49 Is your baby well? yes I

no 2 5

Q50 If no, what is the matter with him/her ☐ 7

Q5I How are you feeding him/her?

breast I

bottle 2

breast + bottle 3

baby in SCBU (not fed by mother) 4 ☐ 8

Q52 Do you feel you were given enough help and support with feeding your baby by the hospital staff?

enough help I

not enough help 2

didn't need help 3

baby in SCBU 4 ☐ 9

Q53 Are you well yourself? yes I

no 2 ☐ I0

Q54 If no, what is the matter with you? ☐ I2

Q55 Is there anything about your care in the ward which you feel is particularly good?

☐ I3

Q56 Is there anything about your care in the ward which you weren't happy about?

☐ I4

Q57 Generally speaking are you satisfied or dissatisfied with the attention and treatment you have got from the nurses since you have been in the ward?

satisfied	I	
satisfied with reservations	2	
dissatisfied	3	☐ I9

Q58 Generally speaking are you satisfied or dissatisfied with the attention and treatment you have got from the doctors since you have been in the ward?

satisfied	I	
satisfied with reservations	2	
dissatisfied	3	
haven't seen a doctor	4	☐ 20

PART IV - GENERAL SATISFACTION AND DEMAND FOR CHANGE

Q59 During your antenatal care and since you have been in hospital were you given any conflicting advice or information from doctors or nurses?

yes	1	
no	2	☐ 21

Q60 If yes, what was it about?

☐ 23

Q61 Who told you this?

2 doctors	1	
2 nurses	2	
doctor and nurse	3	
no conflicting advice	8	☐ 24

Q62 If you were to have another baby and if you could choose where to go for the birth would you prefer to-

come back here	1	
go to another hospital	2	
have a home birth?	3	☐ 25

Q63 (If patient does not want to come back to this hospital) Why would you not come back here?

☐ 27

Q64 (If patient prefers home birth) Would you still make the same choice about having your baby at home even if that meant there was a slightly increased risk to the baby's life and health?

yes	I	
no	2	
doesn't prefer home birth	3	☐ 28

Q65 If you had a choice, would you prefer to be looked after by a doctor or by a nurse/ midwife during your antenatal check-ups?

doctor	I	
nurse	2	
wouldn't mind which	3	☐ 29

Q66 If you had a choice, would you prefer to be looked after by a male doctor or by a female doctor during your pregnancy, labour and delivery?

male doctor	I	
female doctor	2	
wouldn't mind which	3	☐ 30

Q67 How many days do you expect to be in hospital altogether?

☐☐ 31-32

Q68 Do you think this is

too long	I	
long enough	2	
not long enough?	3	☐ 33

Q69 How many days is it since your baby was born?

☐ 35

PART V - FACTUAL DATA

Q70 What age are you? (years) ☐☐ 40-41

Q7I Where do you live?

Dublin	I	
rural	2	☐ 42

Q72 When did you leave school?

after: primary school	I	
secondary school (technical)	2	
secondary school (academic)	3	
third level (technical)	4	
third level (university)	5	
no schooling	6	☐ 43

Q73 Are you covered by medical card?

yes	I	
no	2	☐ 44

Q74 Are you covered by VHI?

yes	I	
no	2	☐ 45

Q75 Accomodation:

public	I	
semi-private	2	
private	3	☐ 46

Q76 What is your husband's occupation?

If a farmer, how many acres does he have?

If self-employed, how many employees does he have?

SOCIAL CLASS CODE

UK Registrar General's Scale. ☐ 48

Medico-Social Research Board Scale. ☐ 49

Irish socio-economic group classification. ☐☐ 50-51