To What Extent do the Categorisations of Novice and Expert Contribute to an Understanding of the Evaluation and Communication of Service Provision in the Maternity Services

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A thesis submitted in partial fulfilment of the requirements of Napier University for the Degree of Doctor of Philosophy

September 1999

ABSTRACT

Introduction

Measuring consumer expectations and perceptions of service provision is supported by both practitioners and academics. The National Health Service, as a result of policy reforms and structural changes, recognises the role of the patient in health care and is gradually incorporating patient views in policy and practice. This study explores the experience of the patient and its affect on the expectations and perceptions of the service provision. Two hospitals, antenatal and postnatal groups were utilised to ascertain the views and experiences of pregnant and recently delivered women.

Methodology

Focus groups were held with women who had delivered, since the implementation of the Patient's Charter, to establish the expectations of the women using the service provision. Issues of priority to these women and the perception of their overall service experience were also considered. In-depth interviews were then conducted with pregnant women to identify expectations of their forthcoming delivery and subsequent in-depth interviews were conducted with the same women once they had delivered their children. This was to evaluate their perceptions and compare them with their initial expectations. Finally, key themes and recurrent ideas were tested, using hypotheses developed after the qualitative research. The questionnaire approach was to substantiate or discount the findings of the first two stages of the research.

Dissemination

Familiar service quality attributes were recognisable from the analysis of the comments. Although there were issues on which women agreed unanimously, many elements of the service provision were viewed differently by women with experience and women from varying categories of residential area. The results also demonstrated that the use and dependence of referent groups varied between the women and that this was imperative for communication. Statistically, the use of referent groups, substantiated through the questionnaire analysis, provided significant results to support the initial findings.

Contribution

Using the information from the qualitative research, a Maternity User's Matrix was developed identifying key characteristics of users' of this service provision. The significant results from the quantitative research were used to develop an existing consumer behaviour model. Using expectations, levels of satisfaction and perceptions of consumers, this research has implications for service provision, health practice, future research and service itself.

This thesis is dedicated to my parents, Barbara and Brian Nimmo, because of their love, encouragement and support

ACKNOWLEDGEMENTS

Many people have helped and supported me through this study and I am extremely grateful to the following:

John Ensor, Graeme Drummond and the late, but wonderful, Neil MacPherson who motivated, inspired and guided me through the study

Dr.Barbara Morris for her time, for considering drafts of the chapters and for all her constructive criticism

My colleagues at Southampton Institute, in particular, Professor John Latham, and the staff in the marketing subject group for their helpful, constructive criticism. I would especially like to thank Ashok Ranchhod, Associate Professor and Head of Marketing, for his objective wisdom, his ability to listen and his attention to detail

Tom Thomas for his impressive knowledge of statistics and his ability to communicate that knowledge

All the midwives, managers and clerical staff - thank you for your time and your interest

All the women who participated in the focus groups and in-depth interviews and completed the questionnaires at a time when they had better things to do

Dr.Grainne Shields for her patience, time and her generosity in providing literature to support the study

Yasmin Sekhon for covering my teaching, taking an interest and making me laugh when I needed it most

Lisa Conaghan, my sister, for all her encouragement throughout the study

Rebecca, my daughter, who was the inspiration for this study and my son, Toby, who reminded me of the special nature of the maternity provision

Lastly to Ade - you are wonderful - thanks for all the help with the diagrams and our children. No more trips to the Sea Life Centre on your own - promise!

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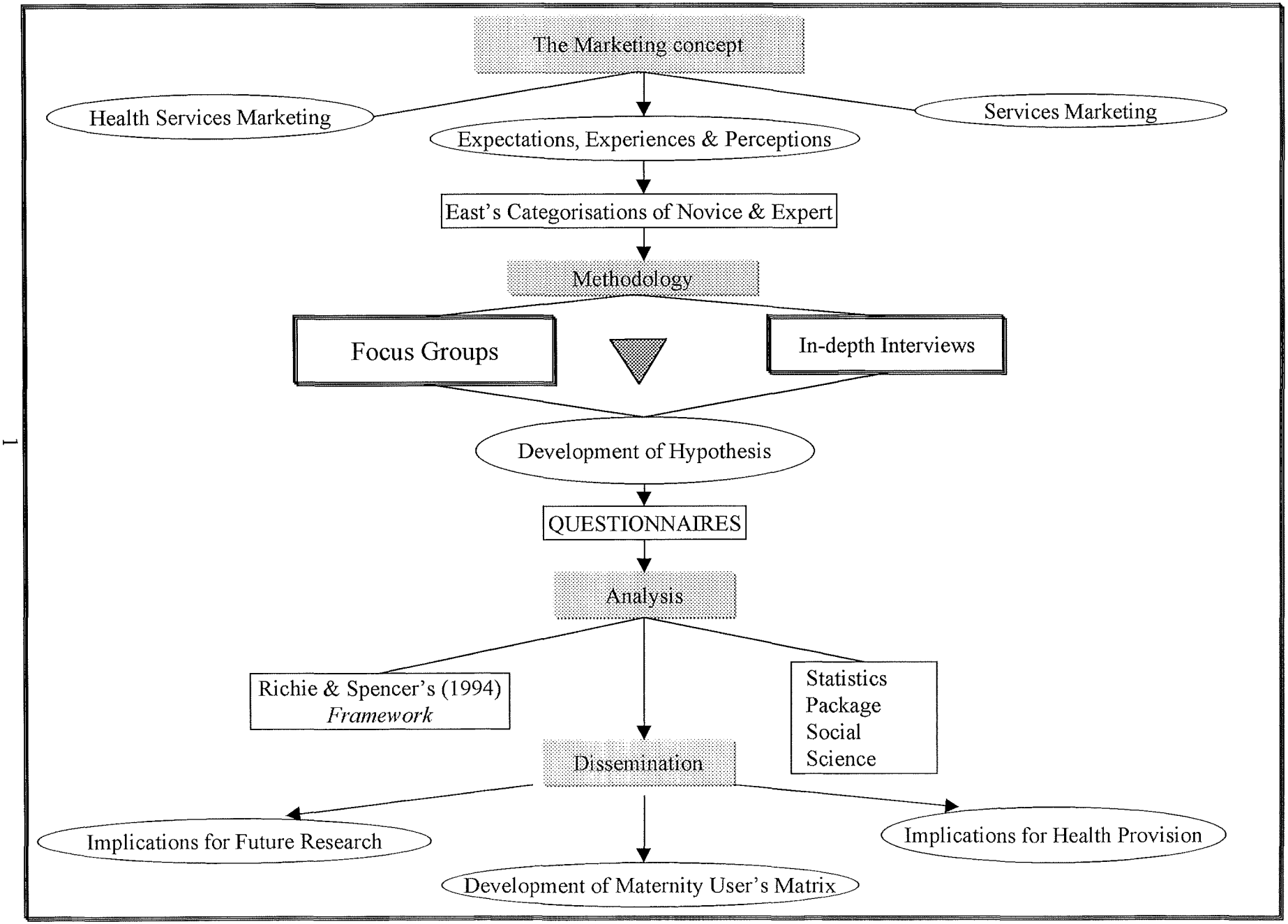


1.0 Overview Of Thesis

CHAPTER ONE

1.1 INTRODUCTION

During the last five years there has been an unmistakable change within the NHS and particularly the Maternity Sector because of polices such as the Patient's Charter (1991), Changing Childbirth (1991), Provision of Maternity Services in Scotland (1993) and because of changes in practice (Consulting Consumers, 1993). Extensive studies into the diversity of patient views on service provision have been conducted [See: Beard, 1992; Beech, 1995; Bell, Morris & Berman-Brown, 1993; Brant, 1992; Burns, 1992; Moores, 1993; McAlister, 1994] and reports have illustrated the obstetrical services as the new focus of marketers (Stevenson, Marshall & Javalgi, 1995).

A move towards delivering services which are responsive to the needs of the user was a result of the development of the Patient's Charter, 1991 (CRAG/SCOTMEG, 1995). Under the terms of the Patient's Charter, health care institutions are required to monitor the service they provide. However, the criteria, which are currently used to reflect the consumers' perspective of service provision, are considered to be ineffective (Bell, Morris & Berman-Brown, 1993).

The service provision for patients using the NHS has become the focus for initiatives to improve levels of satisfaction. Within the provision set out for the Maternity Services, satisfaction is foremost as the patients or consumers using the service are not technically "ill". Indeed, women using this service are likely to be healthy and closely monitored for any signs of ill health. Therefore, maternity consumer's expectations operate on many levels and, although these may be influenced by emotion and behaviour, the expectations and perceptions are not often influenced by illness.

1.2 THE STUDY

This study focuses on the expectations and perceptions of women using the Obstetric Services in Edinburgh. The methods utilised for the empirical research were focus groups, in-depth interviews and questionnaires. This study concentrated on the women using the service and these women were sampled from as wide a cross section of the population as possible. Essentially, the women recruited for the research attended either one of the two major maternity units in Edinburgh. However, not all the research participants were recruited at the hospitals and this is considered in Chapter Three.

The Obstetric Services and their patients are different from the majority of individuals using the NHS as these women are usually healthy. For the empirical research this was an obvious advantage as the women were likely to be more objective about their antenatal care. Yet, the main reason for choosing the Maternity sector, over other departments in the hospital, was due to the likely level of expectation. As part of the empirical study was to follow the research participants through the maternity process and, was to consider if experience changed any of the expectations and perceptions, the study needed participants who were aware they would be attending hospital. Departments such as Accident and Emergency were not considered as an option.

Additionally, the forty weeks gestation provided a specific time period in which expectations would be gathered and although the women would wait for their labour as other patients wait for their treatment, labour could not be delayed; whilst hip replacements, amongst other operations, could possibly be delayed.

The Importance of Choice

Our previous Prime Minister, John Major, (1991) compared public and private organisations, highlighting the differences between the two, whilst demonstrating his desire to increase both choice and competition in the public sector. For women using the Maternity Services, the choice can be somewhat inhibiting, particularly

as they become the new focus of marketers in obstetrical services (Stevenson Marshall & Javalgi, 1995). A common assertion in the literature is that all women have the right to information and therefore the right to make an informed choice (AIMS, 1992). Clearly, the continuing fragmentation in the market place demands a diversity of information, for a number of environmental and structural reasons.

Environmentally, in the early part of the century, the infant mortality rate was so high that all women were encouraged to have their children in hospital and home-births were to be phased out. Ninety eight percent of women now give birth in hospital; despite strong views on the question of place of birth (Health Committee, 1992). Furthermore, within the marketing environment there has been a change in the family structure - a move away from the nuclear family and the rise of the single person household. The average age of women having children has increased as well as the average age of couples marrying. In many cases, the choice regarding maternity services is superseded by the decision of when to have children (*The Guardian,* 1996).

Structurally, the variety of delivery options available to women using the obstetric services continues to rise (Stevenson Marshall & Javalgi, 1995). It may be possible for a woman and her partner to choose between birth in a consultant maternity unit, in a GP maternity unit, under a "domino system", or at home, depending on the facilities available in the area (Department of Health, 1991). The DOMINO (Domicilary In and Out) model of care is one in which the woman receives continuity of antenatal, labour and postnatal care. The woman goes into hospital in labour, is delivered, and the transfers home shortly after birth. Other choices may also include a water birth. Therefore, the nature of the service requires it to be flexible and adaptable within the market boundaries.

However, the market boundaries are blurred to a certain extent, as the product is not specific to any given target market. There is undoubtedly the role of the "partner", in addition to the primary role of the mother. If hospitals focus on specialised services to ensure long term survival they must focus on managing

relationships (MacStravic, 1984; 1987; MacStravic and Denning, 1987) ensuring they meet or exceed expectations.

This chapter provides an overview of the study, considering the factors influencing the work and sets the aims and objectives in the context of the research.

1.3 THE PROVISION FOR MATERNITY SERVICES: AN OVERVIEW

This study was conducted in Edinburgh, and the Policy Review on the Provision of Maternity Services in Scotland (1993) details the changes in scale, distribution and type of provision available to current users of the service.

GPs are typically the first contact for pregnant women. Their role is a significant one as they can advise the women on all aspects of their antenatal care and delivery. Howie, McIlwaine & Florey (1989) concluded that 97% of antenatal care was shared amongst general practitioners, midwives and hospital medical staff.

Women using the Scottish Maternity Services continue to deliver their children in hospital. Currently, the number of home confinements is 0.6% of total deliveries. The Royal College of General Practitioners and Royal College of Midwives (1992) view delivery as a team effort with the midwife looking after uncomplicated pregnancies and obstetricians joining when obstetric difficulties occur. Seventy five percent of all deliveries in hospital are carried out by midwives.

Contracts between purchasers of health care (directly managed units, NHS Trusts, voluntary and private sectors) ensures that health services are funded in such a way as to encourage, not only value for money, but more choice and quality.

Changes in the Delivery of Maternity Care

Troutt (1994) discusses the difficulties in implementing systems of care which allow the patient to be "fully informed" and "fully involved" as it suggests equality between the woman and the health care professional. Troutt believes this does not yet exist. However, continuing studies in this area are developing. The CRAG/SCOTMEG, Working Group on Maternity Services report (1995) provides a guide to ensure good practice and is designed to implement a recognised system of care. The report includes details on continuity of care, the appropriate use of skills, and advice on informing pregnant women. This working group wants to deliver a service that is responsive to the needs of the user, and as such, allows the users to become decision-makers.

The degree to which women expect to be informed, and have a choice is explored in this study. The perceptions and experience of these women and factors that influence expectations are also considered. Literature on public sector services, which have often been criticised, facilitated the development of understanding within this specific area.

The following section outlines this research and summarises the elements of each chapter.

1.4 RESEARCH OVERVIEW

Comprising three distinct stages, this work initially considers the views of women within focus groups, to establish the width and depth of expectations on an exploratory basis. Secondly, the in-depth interviews encapsulate the views of women before and after their treatment, highlighting any break in continuity of their expectations. This primary research culminates in a quantitative study of users of the obstetric services, confirming the expectations developed through the focus groups and the in-depth interviews. The research design is illustrated in 1.1.

Research Method	Objectives
Secondary Research	To develop a grounding in the current themes and key ideas involving the health service, users and marketing issues
Focus Groups (Qualitative)	Exploratory study to establish consumer expectations, areas of service dis/content and perceptions
In-depth Interviews (Qualitative)	To identify awareness of the Patient's Charter & to assess the role of experience
Questionnaires (Quantitative)	To establish the extent to which expectations are based on external information and to measure consumer satisfaction with a view to developing applicable knowledge in this area

Figure 1.1 Stages of the Research Design

1.5 ORDER OF PRESENTATION

The objectives of this research are clearly set out in the following structure. This thesis consists of nine chapters and consists of three basic elements; background to the research, primary research and analysis.

Chapters 1 & 2

The first two chapters concisely develop the background to this work. Chapter 1 briefly describes the research, highlighting specifically the factors prompting the work and the objectives that were set to achieve these aims. Moreover, it establishes the significance of the research and the contribution to knowledge within the Health Market.

Chapter 2 contemplates the literature and consists of three sections. Part one originates with Consumer Buyer Behaviour and the history of expectancy theory. This provides the backdrop to the more recent literature on consumer behaviour and more importantly, is a platform for East's categorisations that are utilised throughout this research.

The second section on theory, discussed within chapter two, relates to both polices and practices of the Health Service and, more significantly for this work, the obstetric services. The second part of this chapter indicates the current polices within the Maternity Services and considers current evaluation of these policies. It establishes a foothold for the research, in defining Health Care and more specifically, the evolution of Maternity provision. Part three of Chapter 2 considers the literature that concentrates on the practice of Health Care.

By questioning the role of service through the health literature, the current climate in which the practices are implemented can be established. The evaluation of this service and its criteria are imperative to the overall research and provide a descriptive base on which to monitor and develop this work. Finally, this chapter considers current literature on women's preferences regarding service and the feasibility of these preferences. It establishes current literature available on women's expectations of the obstetric services and precedes this work on expectations.

Chapter 3

Chapter 3 outlines the research approach and the characteristics of the research problem. Whilst considering existing studies, this chapter also contemplates the orientation and configuration of this research. The triangulation of the primary research is explored and consideration is given to the way in which the findings are to be generated. Additionally, this chapter concentrates upon the aims, objectives and methodological design of this work. This chapter is the keystone of this research as it serves as a platform on which the research will be constructed.

Chapter 4

Chapter 4 is concerned with the exploratory nature of the research and discusses the first of the empirical studies. The initial section considers the way in which the extent of expectations amongst women, who have used the obstetric services, was explored. This chapter also contemplates the results and analysis of the data collated during the focus groups. It specifically details the expectations of women and the distinction of expectations, seemingly dictated by residential area. This chapter concludes with an interpretation of the results as indicated by the objectives.

Chapter 5

Chapter five focuses on the in-depth interviews, the second empirical study, designed to measure expectations over a period of time. Initially, this section details the "before" and "after" interviews which were conducted to extract the data. This chapter also considers the results of this confirmatory research and concludes by highlighting the necessity for future data collection.

Chapter 6

Chapter 6 continues in this vein, detailing the implications of this research and the initial empirical studies. More specifically it addresses the questions that have arisen as a result of the primary research, and constructs the future development of the remainder of the research.

Chapter 7

The questionnaires, which are considered in Chapter 7, encompass the future development of the research as outlined in chapter six. Chapter seven focuses on the results of the survey which concentrate on collating expectations, assessing expectations in relation to experience and highlights the use of referent groups within this area.

Chapter 8

The research now ends as the essential findings are brought together. The questions initially raised through the literature and the objectives will be disseminated, within the context of the attainment of the initial objectives. In addition, it considers the limitations of the research undertaken and provides recommendations for future research.

1.6 THE RESEARCH PROBLEM

Practitioners of medicine now recognise that patients are not merely passive recipients of advice and procedures from health care professionals but that they have an active role in their own care (Hopkins, Gabbay & Neuberger, 1994). Consumers make an indispensable contribution to defining quality and setting the standards by which it is to be judged (Donabedian, 1992).

The insight that can, has been and continues to be provided by women using the maternity services provides scope for continual development. The women using the Maternity Services in this research were unique as they provided expectations and perceptions of the service, which allowed experience and the influence of formal and informal referent groups to be considered in the overall equation.

The obvious difficulty with providing a service is the simultaneous production and consumption between provider and recipient. The difficulty in exacting

expectations arises as a result of receiving the service without enough information. If there is not enough information, a woman using the maternity services is not going to have the knowledge to form expectations, let alone make an informed choice.

1.7 CONTRIBUTION TO KNOWLEDGE

This work approached a relatively unfamiliar area with a fresh perspective, utilising categorisations of a consumer model and adapting it to the practices of the obstetric services.

The expectations of women using the maternity services have been reported (Bostock, 1993) not, however, by considering the experience of the patient and the effect of that experience on expectations. Consideration of the use of referent groups as a significant source of developing and influencing expectations will contribute to knowledge within this area.

This research sets out to contribute in the following areas:

(a) To enhance the information concerning the consumers' perspective of the Patient's Charter, allowing the provision for future application of this knowledge

(b) To utilise established consumer categorisations to incorporate expectations and experience of users of the maternity service provision, enabling a greater depth of understanding into consumer behaviour within this area

(c) To establish key themes and recurrent ideas by using qualitative research and to substantiate these issues through triangulation of data

(d) To explore and identify changes in the views of antenatal and postnatal women regarding attributes of the entire service experience

(e) To consider the views of women from varying socio-economic groups

(f) To extend and adapt an existing consumer behaviour model to incorporate the influence of location and referent groups on health service users' (patients)

(g) To consider past and current users of the maternity services to develop a matrix

The primary objective (See **3.2.4**), because of the lack of data in this field, has been developed using East's categorisation of novice and expert purchaser (1992). Current methods of monitoring consumer satisfaction are not based on previous experience or expectations. Rather, by developing performance indicators to improve both efficiency and customer satisfaction, Smith (1993) argues the NHS use these measures for budgetary control. The literature also considers other methods of evaluation (Brant, 1992; Maxwell, 1992; Bell, Morris & Berman Brown, 1993) which are largely problematic, providing opportunities for development.

Addressing the issues raised from the literature, this research has an exploratory design to examine the extent of expectations of women using the obstetric services. Consequently, two dominant objectives have emerged:

1. To establish the nature of consumers' expectations by utilising East's categorisation to the health care sector; to consider whether there are different types of expectations based on experience and referent groups.
2. To evaluate the provision of health care as determined by the Patient's Charter and to establish if a correlation exists between the expectations of the consumers and the service guided by the Charter.

As knowledge of expectations of women in this particular area is limited, and with the desire to develop East's categorisation, these objectives are designed to use a hybrid methodological design.

1.8 IMPORTANCE OF THE STUDY

With the continuing development of service provision within the public sector, this work provides a current, independent survey of women using the Maternity Services in Edinburgh. The National Childbirth Trust, in addition to medical staff, working groups and employees of maternity units throughout the UK, continues to strive for patient centred maternity care. This research contributes to the overall debate by considering the expectations of women, the experience of women and the effect of these variables on the overall perception of service.

CHAPTER TWO

2.1 THE HEALTH CARE ENVIRONMENT: AN INTRODUCTION

The purpose of this first section of the literature review is twofold. The first purpose is to establish the context of the research. This is set within the issues surrounding the reforms of the NHS and its organisational structure, giving an overview of the NHS service provision as a whole. Secondly, this section focuses on patient satisfaction and the role of patient involvement within the setting of the NHS. Whilst considering the appropriateness of evaluating standards of health care, arguments which detail academic, professional and consumer opinion on the role of patients are taken into consideration. This overview sets the primary research (which is presented in the later chapters) into context.

2.1.1 Why Reform?

Essentially, before the introduction of management and structural reforms, the NHS was a product-driven, organisation-centred institution. Arguably, despite the reforms, the NHS has remained product, rather than consumer, focused (Glazer, 1995; Kennedy & Nicholls, 1995).

In summary, the re-structuring and re-organisation of the NHS emerged as a result of the following:

- The necessity to improve efficiency and service quality
- To bring more private money to the system by encouraging providers to market themselves to private as well as public purchasers
- To make the service more consumer oriented by empowering the patient

(Tibbets, 1994)

The financial and service inefficiencies, the complexities of the existing structure and the role of the patient were clearly the impetus for change although the importance or significance of each of these key elements for reform is a contentious debate (Maxwell, 1992; Moss 1992 & Smith 1993). Our previous Prime Minister, John Major (1991), expressed that his desire for reform was fuelled by a need to increase competition and choice in the public sector. Regardless of the reasons for reform, far reaching consequences for end-users, consumers and service providers were inevitable in the re-organisation of an institution such as the NHS.

2.1.2 Efficiency and Service Quality

Sir Roy Griffiths was approached by the government in 1982 to produce a report on health services management. As Griffiths was the managing director and deputy chairman of the retailer Sainsbury Plc, he was considered an appropriate candidate to comment on the management of the NHS. His report, the 1983 Griffiths Report, was highly critical of management at all levels in the NHS (Ham, 1991). Specifically, Griffiths commented on:

- The lack of a clearly defined general management function
- No driving force seeking and accepting direct and personal responsibility for developing management plans
- Doctors being looked upon as natural managers as the nearer the management process gets to the patient

The Secretary of State accepted the findings of the Griffiths report, announcing the implementation of the recommendations (1991). Therefore, general managers who would be accountable for the total performance of their organisation were appointed at unit, district and regional level. These general managers were to be introduced on short-term contracts with performance related pay. Each individual would have a management performance review. Each unit was to be considered as

a Strategic Business Unit (SBU) in the conventional 'business state'. It was hoped that by introducing these recommendations that efficiency and service quality would be improved. However, few mechanisms to implement innovations regarding service quality or consumerism were in place (Harrison et al, 1990).

2.1.3 Competing Elites

With the introduction of general managers, competing elites emerged in the form of medical professionals and managerial staff. Although both groups were technically working for the consumers of the service, obvious differences in role and expectation caused inevitable strain between the two groups. Additionally, Bell et al (1995) commented that "health professionals" are reluctant to recognise specialist knowledge in groups other than themselves. Competition within a group, such as the medical professionals, therefore was as apparent as that of the competition between the two elite groups.

2.1.4 NHS Reforms: A Cultural Shift

As the effects of the implementation of the Griffith's recommendations were surfacing, a major re-organisation of the NHS was announced in the White Paper *Working for Patients* (Department of Health, 1989) and was introduced from April 1991. The recommendations of the Griffiths report had a number of effects before the White Paper was in place:

- A variety of management arrangements were adapted to suit local circumstances as opposed to the use of management teams that had the same membership regardless of location
- Local arrangements were inclusive of responsibility for quality assurance
- Units of management had devolved decision making powers from District Health Authorities and, in addition to these changes, the NHS management

board provided a programme not only management budgeting, but also for the resource management programme

Before *Working for Patients* was derived then, doctors and nurses had, in an effort to improve patient care, been given a greater role in the management of resources with clinical teams being given responsibility for devolved budgets within the hospital environment. Managers were to negotiate workloads with clinical teams, whilst staff were to be provided with a greater depth of information regarding the service they provided.

2.1.5 Purchasers & Providers

These changes and recommendations were further developed within the history of the reforms by the introduction of *Working for Patients* (Department of Health, 1989). This was a result of the assumption that the separation of two functions previously combined in the role of District Health Authorities (DHA's) would produce a service which was both rationally planned and more efficient (Harrison, Small & Baker, 1994). The first of these functions was the purchasing decisions for a specifically defined geographic population, with the second focusing on the provision of care.

The separating of these functions, theoretically, would allow purchasing decisions to be made for assessed population needs with providers competing for resources and driving down costs and/or producing a better quality of service (Harrison, 1991). Measuring and assessing the quality of service and the efficiency of funding was considered an essential element of the overall reforms.

2.1.5.1 Maintaining Professional Boundaries

A systematic methodical assessment of measuring clinical practice was utilised in the 1980s by a few pioneer units and the medical audit was subsequently

introduced in the 1990s as part of the package of reforms (Moss, 1992). Medical audit offers a setting in which the quality of care can be measured, with these measurements including agreed standards that are assessed in a structured and critical manner.

Yet, difficulties in assessing quality of routine clinical care are widespread as inter-professional or "tribal" boundaries exist with little available information on routine practice. Audit without commitment to change is unlikely to have any effect on clinical practice. Although funds have been given for medical audit development, including staff costs, training and information technology (Ham, 1991), patient views have never predominated (Moss, 1992).

2.1.6 The Quality Initiative

The Griffiths Report (1983) established the importance of quality and the introduction of the reforms provided the platform for the issue of quality to be considered as more than simply employing resources efficiently. Medical audit, clinical audits, contracting, clinical and non-clinical standards were cited as practices which were inherently associated with quality.

Practitioners set criterion for effective quality standards, through the implementation of the initiatives outlined above. In addition, as interest, pressure and concern for quality developed, Total Quality Management (TQM), its relevance and organisational approach were implemented throughout hospitals and community services (Koch, 1991). Developing a quality culture, in which expectations of patients were known and met, if not exceeded, increased the necessity for patient views to be included in quality initiatives.

Obstacles to implementing a quality programme however, are far reaching, and include:

- lack of top management commitment and vision

- a lack of structure for TQM activities

Quality activity can be limited by the maintenance of professional boundaries. Consequently, the majority of patients' views continue to be collated sporadically through patient surveys.

2.1.6.1 The Patient Perspective

A commonly used definition of quality is the extent to which services meet the customer's needs (Brant, 1992). The use of patient surveys to assess these needs would appear to be appropriate as service providers have valuable assets in consumers' opinions. People who use the health service are often from differing social or ethical backgrounds. They can give information regarding access, choice, information, safety, redress, representation and effectiveness (Scottish Consumer Council, 1994).

Yet badly designed questionnaires (which have restricted or limited responses) are not unusual (Brant, 1992). Additional problems include lack of specificity about standards on which they are based, the individualised nature of care and, more significantly, the lack of systematic observation and analysis of professional competence and practice (Ellis & Whittington, 1994).

As Britten & Shaw (1994) observe, although the Patient's Charter (Department of Health, 1992, 1995) includes ten rights for patients, with nine national standards, the standards were devised as part of the Citizen's Charter, *not through consultation with patients.*

2.1.7 Patient's Charter

Ham (1997) highlights the importance of aspects of quality by recognising the effects of the publication of league tables on the performance of providers. These league tables are based on the Patient's Charter (1991), and include measurable quality standards for patients. The ten rights of the Patient's Charter are not all applicable to users of the maternity services, but those that are include:

- being given the right to detailed information on treatment and service provision
- being offered the opportunity to have complaints fully investigated
- to choose whether or not to take part in medical research or student training

The updated and developed Patient's Charter (1995) provides additional guidelines on outpatient appointment times, waiting times for operations, standard "trolley times" in accident and emergency and relative home visits by community nurses.

However, the extent to which individual clinician performance is measured has only been belatedly addressed by Ministers' announcements in 1996. The publication of NHS performance leagues coincided with the announcement that clinical standards may be considered for inclusion in future measures (Ham, 1997). Although the league tables are widely available for comparison, Glazer (1995) observes that the Patient's Charter can do little to address the basic issues of patient care as lack of funding may have adverse clinical effects and will be detrimental to safe, quality practice.

2.2 DIMENSIONS OF PATIENT SATISFACTION

Policy documents, including *'Working for Patients'* (1991), practitioners (Mahon, Wilkin & Whitehouse, 1994) and users of the health service advocate measuring patient satisfaction. The benefits of being aware of consumer or patient views have been reported to include the following (Donabedian, 1992):

(a) A greater likelihood of continuing with treatment

(b) Developing a relationship with the provider

(c) A greater likelihood of complying with medical regiment

(d) User views can be incorporated in the design and delivery of services to promote a better quality of care

Arguably, as the NHS is the only source of health care for the vast majority of people it would be fallacious to suggest that satisfaction with hospital services has been shown by the willingness of people to continue using the NHS (Moores, 1993). However, the debate regarding what actually constitutes patient satisfaction is ongoing (Brant, 1992; Carr-Hill, 1992; Williams, 1994 & Turner & Pol, 1995) and, until the consumption context of satisfaction evaluations are both consistent and explicit (Pascoe, 1983), the discussion will continue.

2.2.1 What is patient satisfaction?

Authors discussing the issue of patient satisfaction are divided in their interpretation of its definition. Definitions of patient satisfaction vary from the simplistic to the complex with the simplistic definitions not fully comprehending the depth of available literature and the complex definitions compounding confusion in the subject area. For Singh (1990), patient satisfaction is simply the result of a process of evaluation of the service obtained from different constructs.

Rubin (1990) observes that patients appear to evaluate the 'technical' and 'interpersonal' features of care in an attempt to define service constructs. Both these definitions indicate that patient satisfaction is based on tangible issues and fail to suggest specific determinants of patient satisfaction.

2.2.2 Determinants of Patient Satisfaction

Yet determinants of patient satisfaction have been identified (Aharony & Strasser, 1993), and these specific service constructs suggest that patient satisfaction has depth and scope not fully comprehended in simplistic definitions. Patient satisfaction is derived from a combination of:

- the attitudes and expectations held by the individual regarding medical care
- the physical and psychological status of the individual
- the structure, process and outcome of medical care

Focusing specifically on attitudes and expectations, these determinants build on existing literature which reports that research into consumer satisfaction has demonstrated that satisfaction is related to the disconfirmation of consumer expectations. Indeed, the majority of commentators make the common sense assumption that a substantial link between satisfaction and fulfilment of expectations exist (Williams, 1994). Studies considering patient satisfaction have defined care as the degree of congruence between patient's expectations of nursing care and their perceptions of care actually received (La Monica et al, 1986).

Williams (1994) however, further considers the literature to be lacking in the number of relevant criteria which would support the common sense assumption that a substantial link between satisfaction and fulfilment exists. Whilst suggesting commentators have legitimately considered their assumption, Williams indicates that this link between satisfaction and fulfilment no longer contributes to a greater

depth of understanding of patient satisfaction. Whilst, he concedes, there is evidence to suggest expectations and values are involved in overall measurement of service, the complexity of the linkage is beyond simplistic analysis.

It may be that patient satisfaction is impossible to define as a result of heterogeneity (see **2.3**). As Carr-Hill (1992) suggests, satisfaction is a complex concept that is related to a number of factors including lifestyle, past experiences, future expectations and the values of both individual and society. If expectations and perceptions do not accurately reflect patient satisfaction, a greater depth of understanding of past experiences, lifestyles and norms in society need to be considered.

2.2.3 The Importance of Measuring Satisfaction

Although patient satisfaction cannot be overstated in the measurement of health care quality, patients have a complex set of important and relevant beliefs that cannot be embodied in terms of satisfaction (Turner & Pol, 1995). Lin and Kelly (1995) similarly observe that whilst satisfaction with delivered services is important; concentrating on it alone fails to fully address customer needs. To comprehend the evaluation of any service requires depth of analysis.

The importance of all elements of patient satisfaction and quality in care cannot be underestimated as understanding an evaluation of performance for one service encounter ultimately leads to a customer's overall perception of service quality (Turner & Pol, 1995). Indeed, the disagreements over the reason for measuring and defining satisfaction highlights the importance of specifying the scope of satisfaction (Carr-Hill, 1992). The difficulty in assessing satisfaction arises as a result of different instruments being used to measure aspects of satisfaction from one study to the next (Hall & Dornan, 1988). The ability to compare and generalise on the issues of measuring and defining satisfaction is, therefore, limited in its scope.

2.2.4 The Effectiveness of Evaluating Standards of Care

Methodological difficulties in measuring patient satisfaction has been extensively explored [For example see: La Monica et al, 1986; Brant, 1992; Carr-Hill, 1992; Williams, 1994 & Turner & Pol, 1995] and agreement on how patient satisfaction should be evaluated is yet to surface. Dilemmas facing academics and practitioners in measuring patient satisfaction are widespread. Little or no consistency exists amongst theorists on what constitutes patient satisfaction (See **2.2.3**). There is a lack of standardised approaches to patient satisfaction questionnaires. The varying roles of patients and professionals and the heterogeneous nature of the NHS provides an insight into the difficulties of researching patient satisfaction.

Patient satisfaction questionnaires and methods of collating data using the survey method is widely reported as flawed and methodological difficulties are associated with the following research instruments:

- Timing of Survey
- Sampling Frame
- Non response bias
- Response Format
- Incentives to increase response rates
- Use of Proxies

The following section considers each of the major factors affecting the accurate recording of patients' views, and in turn, patient satisfaction.

2.2.4.1 Timing of Survey

The literature suggests that the timing of a questionnaire influences the degree to which patients record their experiences as satisfactory. As Carr-Hill (1992) suggests, the longer the delay between the use of services and the survey, the greater the chances of re-call bias. Patient views are known to change positively over time due to a result of external factors, such as the outcome of treatment (Bamford & Jacoby, 1992). Therefore, the greater the gap between the service exchange and the satisfaction questionnaire, the greater likelihood of the researcher recording positive responses.

However, patients surveyed during their stay, as opposed to after their discharge, were reported to have expressed greater overall satisfaction (Aharony & Strasser, 1993). This may be as a result of the patient gratitude and inexperience outlined by Brant (1992):

The Halo Effect:	"I'm so happy I'm better"
The Hawthorne Effect:	"I'm in expert hands"
The Helpless Effect:	"I'm so grateful for the care I am receiving"

Alternatively, as Avis (1995) observes, the relief patients feel at having survived threats to their dignity was an important factor on influencing expressions of satisfaction in his study. If the patient's experience had not involved extensive medical intervention, the patient may record being satisfied with the service, whilst simply being relieved at the lack of an intrusive examination.

Finally, French (1981) records that post-discharge studies appeared to have a lower response rate than in-patient response. This could be as a direct result of feeling less gratitude and, therefore, fewer obligations to complete a questionnaire outside of the treatment period. In addition, as greater perceived severity of illness

during hospitalisation has been associated with poorer evaluations of care, the bias associated with the timing of administering a patient satisfaction questionnaire can be compounded by the selection of the sampling frame.

2.2.4.2 Sampling Frame

The selection of patients completing satisfaction questionnaires is also flawed in research studies considered by academics and practitioners and is explored through the methodological problem of non-response bias. An example of poor sampling is highlighted in the study conducted by Rubin (1990) as, although a lower response rate for questionnaire completion was recorded for discharged patients, the same piece of research excluded very ill in-patients and those whom staff did not want surveyed.

Lin and Kelly (1995) advise that if comparisons between patient satisfaction and a given medical condition are being made, problems could arise if such surveys are used without reference to a target population. The sampling frame of any piece of quantitative research relies on the respondents taking part. If only those responding to the survey are, for example, educated with a high disposable income, any implementation of the interpreted findings may provide a better service for this type of patient only. Additionally, any reporting of the findings will lack both credibility and generalisability.

Yet the likelihood of hospitals implementing findings derived from patient satisfaction questionnaires are poor. Moores (1993) indicates that very few [hospital authorities] actually claimed to have introduced any fundamental changes because of the findings [of patient satisfaction questionnaires]. This is supported by Spencer (1996) as he observes that all too often it seems that consumer satisfaction surveys are conducted, the recommendations are made, but then no strategy is implemented to make any changes to the service. It may be, however, that faith in the results are limited as a result of the problems of sampling.

2.2.4.3 Non response bias

Patients may not complete questionnaires, as they believe that any contribution they make will not change either the service they have just received or the service they will receive in the future (Donabedian, 1992 & Williams, 1994). More research into the views of non respondents needs to be conducted, as generally the only criterion by which the effectiveness of questionnaires is judged is the overall response rate (Bamford & Jacoby, 1992). If this continues to be the case, the views of the non-respondents, which are as equally as important as those who complete satisfaction questionnaires, will be lost.

Carr-Hill (1992) further explores the non-response bias, recording that the characteristics of the intended and achieved samples are rarely compared. As published research results of patient satisfaction questionnaires vary from 33-92% in response rates (Aharony & Strasser, 1993) the generalisability of the results is at best questionable.

2.2.4.4 Response Format

The way in which questions are posed by the researcher is also open to criticism. Strasser & Davies (1990) provide evidence that open-ended questions are more negatively answered and this is supported by Brant (1992) as her findings indicate that questionnaires which contain closed or leading questions encourage patients to agree with the given statement. Patients desire to give socially acceptable answers (La Monica, 1986) and this is frequently cited as a cause of high satisfaction scores.

As the level of criticism expressed by patients depends on the context and way in which questions are asked (Carr Hill, 1992) those who are uncomfortable in disagreeing with positive satisfaction statements might be more comfortable agreeing with negative statements (La Monica, 1986). That is, because the patients

consider the negative statements to be an acceptance on the part of the professionals that the service provision is not perfect. In these cases, a more honest and varied response is typically achieved.

Moss (1992) and Spencer (1996) advocate input from users of the service for the questionnaire design. In essence, what the professionals think is important for the client is not necessarily a reflection of what the client believes to be important. Replies presented as if spoken in the first person effectively put words into the respondents' mouths, again reducing the validity and credibility of the report findings.

2.2.4.5 Incentives to increase response rates

The incentives to encourage patients to respond to satisfaction questionnaires is an established practice whether it involves the inclusion of a reply-paid envelope, the use of an interviewer familiar with the hospital, techniques for "getting a foot in the door" or offering a monetary incentive (Lin & Kelly, 1995). Incentives to increase response rates have been observed for many years. In 1957, Abdellah & Levine recognised that patients were not as communicative when the interviewer wore a lab coat as when she was in nurse's uniform.

Although incentives to increase response rates is not a new concept, any incentive must be considered a limitation in an overall study as the respondent enticed by an incentive may be completing the questionnaire for the incentive only. The inclusion of this data in the overall sample would need to be considered in comparison to respondents who completed questionnaires without an incentive to add weight to the generalisability of the sample. Often, however, incentives are given to everyone, so the bias is reduced.

2.2.4.6 Use of Proxies

Finally, it has been recognised that relatives or friends, questioned about the treatment of the patient, viewed the care more negatively than the patient did themselves (Aharony & Stasser, 1993). This finding supports Brant's Halo Effect (1992), that suggests that patients are so happy to be better that they believe they have received satisfactory care. Perhaps for areas of future research, the inclusion of an alternative view of patient care and satisfaction may be sought by the use of proxies.

2.3 SATISFACTION V CONSUMER HETEROGENEITY

Typically, 80% of patients who respond to patient satisfaction questionnaires are satisfied with their care (Brant, 1992; Bamford & Jacoby, 1992) and it has been reported that patients consider the concept of satisfaction as a meaningful one to use (Avis, 1995). This would appear to question the necessity for continually monitoring patients' evaluation of the quality of the service provision they receive. However, the methodological problems outlined in the previous section (**2.2.1-2.2.4.6**) suggest that the quality of data collated on patient satisfaction provides limited scope for both validity and generalisability.

As individual encounters may contribute to a deeper understanding of the nature of the physician-patient relationship improving the quality of collated data on patient satisfaction focuses on qualitative research and the promotion of a multifaceted view of patients' perception, evaluation and satisfaction (Singh, 1990). There is a lack of evidence to suggest patient satisfaction has actually improved the quality of care for patients (Spencer, 1996) and, as such, in an effort to improve the service encounter, the search for accurate patient views continues.

2.3.1 Acceptability

The elements of quality patients consider to be important have been, to some extent, explored in the literature. Despite methodological difficulties previously outlined, pertinent issues that affect patient satisfaction have been reported as:

- humanity
- efficiency
- ease of obtaining information
- continuity of communication

(Avis, 1995)

Perceptions of service quality, however, can be differentiated based on their causal agent (Dube, 1996) with these agents including the individual, other people and/or the situation itself. The issues affecting patient satisfaction are widespread and the level of quality acceptable from one individual to the next will vary (Moore, 1993). Essentially, the heterogeneous nature of the NHS service provision heightens the difficulty of generalising patient views.

2.3.2 Similarities

Rather than dismissing the evaluation of patients' perceptions of service quality, a variety of methods have been considered and employed to overcome problems of generalisability. Groups of individuals, for example, will have similar expectations and perceptions (Lin & Kelly, 1995). Addressing the sampling frame in any given study should provide accurate data that can be used for comparative studies.

In addition, Carr-Hill (1992) discusses the concept of practical and ideal expectations. This explores the threshold of acceptability from one person to another. Although individuals will have ideal expectations, there will be an

acceptable level of service quality that can be generalised and categorised as "practical". Indeed, the patient feeling that he/she has generally been treated with fairness is just as important as part of the overall process (Aharony & Strasser, 1993) with little, if any, support for believing that patients think and evaluate in terms of a continuum of satisfaction (Williams, 1994).

2.3.4 Varying Roles of Patients and Professionals

If satisfaction differs across patient populations or medical encounters (Aharony & Strasser, 1993), arguably the heterogeneity of any given patient population could be addressed with an accurate sampling frame. However, the importance placed on the varying roles of patients and professionals are considered in this section to explore if:

- Patients want their views to be implemented at a strategic level
- Professionals consider patient views appropriate during the physician-patient medical encounter

The roles of patients and professionals are defined in as much that patients and the public may be unable to judge if the care they are receiving is the best possible to improve their health (Rubin, 1990). Patients may not be educated or informed enough to assess the quality of the technological aspects of care and this is known as *credence*. The professional will assume the role of the "expert", with the patient being dependent on this knowledge. To this end, the general perspective implies that patients do not - or should not - evaluate clinical practice (Carr-Hill, 1992).

2.3.4.1 The Professional's Role

Spencer (1996) observes that there is a tendency amongst professionals to assume that they know all the answers - unlike the less informed patient. This suggests

professionals consider patient views inappropriate during the patient-physician medical encounter. Supporting this view, Humenick and Bugen (1981) observe that within the maternity provision well meaning health care providers are perplexed or irritated when women express a desire to make meaningful decisions related to childbirth.

2.3.4.2 The Patient's Role

Yet patients, although initially prepared to play a passive role, increasingly want to play a more participative role (Avis, 1995). Patients can perceive benefits from emotional support that they receive from staff (Dube, 1996) so that even if they cannot assess specific medical treatment, their overall views remain important. Clearly, patients consider their views to be important. The extent to which they perceive themselves to be powerless, influences the way in which they frame their expectations (Carr-Hill, 1992) and ultimately their overall satisfaction.

If the above views are accepted as an accurate description of current practitioner-patient roles, then the most prominent aspect of these relationships is the opportunity created for conflict. If patients do wish to play an increasingly participative role, the users of the maternity provision specifically, with increasing knowledge and information, will want to make significant decisions regarding their care. Unless a more co-operative and accommodating role is adopted by the professionals, conflict within these relationships will continue.

Summary

The first section of this literature review has raised the salient issues of NHS reform, including cultural shifts, the roles of the purchasers and providers of health care and the implementation of quality initiatives. Whilst focusing on the Patient's Charter, this section additionally sought to consider the patient perspective, indicating topical areas within the satisfaction literature for establishing the

necessity and importance of measuring patient satisfaction. Methodological difficulties associated with assessing satisfaction were also explored with a discussion on the potential for validity and generalisability within studies on patient satisfaction. This has provided the initial platform for the context of the research that is detailed in later chapters.

The following section concentrates on quality, satisfaction, behaviour, attitude and expectations in an effort to develop further the broader concepts of the research as a whole.

2.4 DIFFERENCES IN EVALUATION ACROSS THE SERVICE SECTOR

2.4.1 The Concept of Service

A broad range of literature over the last twenty-five years [See for example: Levitt (1972), Berry (1980), Lovelock (1996) and Rust, Zahorik and Keningham (1996)] identify the intangibility of services as problematic (Gabbott and Hogg, 1998). That is, because of services being simultaneously produced and consumed, measuring the fundamental characteristics of services has been challenging. As such, authors often propose responses to this problem by focusing on tangibles such as physical dimensions or standardised delivery.

As services are receiving increased management attention, resulting from the proliferation of service industries world-wide, and because of the implications for employment and economic performance (Haynes and DuVall, 1992), the definition of service, the benefits of service and understanding service as a concept have featured in both academic and professional literature.

Although service itself is ambiguous, the parties involved have to objectively measure all the elements involved in the exchange and evaluate their quality (Gabbott and Hogg, 1998). Definitions of service often consider the outcome of a

service encounter and, as service is usually measured in degrees of satisfaction and if the customer will come back and use the service time and time again, the focus is on the outcome rather than the process.

Service provision varies between organisations and individuals but what is important and what is less apparent, is why consumers desire the goods and services on offer and what is the nature of the value that they place on, or obtain from them (Gabbott & Hogg, 1998).

Encompassing a complex and diverse range of both organisations and enterprises, the service sector includes three distinct types of provision (Ghobadian, Speller and Jones, 1993):

- national and local government
- non-profit private services
- for profit service private services

Although this thesis focuses primarily on health at national and local level, major differences between manufactured products and services are readily visible (Lockyer, 1986) and also exist within non-profit and profit private services. The defining characteristics of services detailed below are applicable to the three distinct types of provision identified above.

2.4.2 Inseparability

Typically the service will be created or performed at the same time as the full or partial consumption of the service takes place. The degree of involvement between the transacting parties is dependent on whether the service is "equipment-based" or "people-based". Essentially, if the service provider is human as opposed to a machine, the encounter will inevitably vary between service deliveries. People are

less standardised than machines, which obviously has important implications for the process of evaluation (Gabbott and Hogg, 1998).

2.4.3 Intangibility

The consumer cannot see, feel, hear, smell or touch the product before it is purchased (Ghobadian, Speller and Jones, 1993). It is one of the most important characteristics of service products as consumers can only experience the performance of the service (Gabbott and Hogg, 1998). This makes the perception of a service highly subjective and reinforces the importance and significance of the evaluation process. Zeithaml (1981) suggests that one needs to experience a service before it can be understood. This is supported by Gabbott and Hogg (1998) who indicate that in any pre-purchase situation, the product will remain abstract until it has been consumed.

2.4.4 Perishability

Services cannot be stored for consumption later. As such, it is not possible to have a final quality check (Ghobadian, Speller and Jones, 1993). The time at which the consumer chooses to use the service may be critical to the performance of the service and, therefore, to the consumer's evaluation of the service experience. Kelley, Donnelly and Skinner (1990) observe the link between service consumption and the presence of other consumers. Indeed, the absence or presence of other consumers can adversely affect the service outcome and the consumers' perception.

2.4.5 Heterogeneity

As services are delivered by individuals, each service encounter will be different. This is because of the current situation, the time-period chosen to consume the service and the participants in the exchange. The inability to replicate services, in

the same way products can be standardised, has significant implications for service management as well as for consumers. Gabbott and Hogg (1998) however, advocate where individual and interpersonal exchange is involved the customisation or personalisation of services may be as appropriate, if not more so, than a standardised approach.

2.4.6 Ownership

Kotler (1982) considers ownership as a distinguishing characteristic of service. This is because the purchaser only has temporary access to a service as opposed to the complete ownership they would have of a product. The benefit of the service is owned by the consumer. The absence of an actual product highlights the ultimate nature of services and the difference between the involvement of a consumer with services and products.

2.4.7 Evaluating Services

As previously identified, the consumption of services by individuals is difficult to objectively evaluate as the consumer is inherently involved in the overall process. Within the health service context, the experience of the individual can be evaluated in addition to the following groups:

- public and private health providers
- ill and healthy patients
- the patient and the physician

These groups will evaluate the service experience differently and by focusing on the similarities and variations in the experience and perceptions of a wider sample, a more objective view may be obtained.

The service evaluation between public and private health providers will invariably differentiate as a result of resources. Private health provision reduces waiting times for appointments and surgery, whilst providing additional comfort in terms of a pleasant environment, readily available staff, improved food provision and an increased level of privacy. The notion of equity is raised, as only the elite will find private health care affordable.

Ill patients and healthy patients will also have a different perception of their overall service experience. Whilst the ill patient may consider their service to be excellent simply as a result of their health improving (See **2.2.4.1**), healthy patients may use very different criterion to assess their service and may become more critical because they are less "grateful" (Ovretveit, 1990).

Finally the patients perception of their service may be different from the one which the physicians consider themselves to be providing. Proctor (1997) comparatively studied physicians, midwives and patients whilst focusing on service quality within the maternity provision. The results indicated that the patients and the medical professionals had very different views on the service provision and the interaction/relationship between provider and user (patient). This causes difficulties for the managing of expectations and the overall service experience.

The intangibility of services and the inability to quality check the final product before delivery has motivated authors to propose tangible cues that can be used to measure a given service.

The Perceived Quality Model (Gronroos, 1984), based on the dis/confirmation paradigm from the satisfaction literature (Oliver (1980) contained the main components on which Parasuraman, Zeithaml and Berry (1985) designed their Gap Analysis Model. The Perceived Quality Model indicates that the level of perceived quality depends on the direction and extent of the confirmation of customers' expectations by their experiences. The direction could be positive or negative.

Parasuraman, Zeithaml and Berry (1985) attempted to demonstrate activities and interactions present in service organisations that have an affect on service quality. Four service organisations were chosen and included product repair and maintenance, retail banking, credit cards and securities brokerage. From this empirical work, the authors identified five gaps in service provision which impacted on service quality and these were: consumer expectation, management perception, service quality specification, service delivery and expected service. Parasuraman, Zeithaml and Berry also, through their qualitative fieldwork, identified ten dimensions of service quality: reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding and tangibles. However, after a series of further analysis, these dimensions were reduced to the following:

- Tangibles
- Reliability
- Responsiveness
- Assurance
- Empathy

The tangible aspect focuses on the physical facilities encountered by the consumer, in addition to the equipment and overall appearance of employees. The ability of the personnel to perform the service accurately is the central theme of reliability. Willingness to assist is key to responsiveness. The knowledge base and attitude of the individuals providing the service will have an affect on how assured the consumer feels and, therefore, how much trust and confidence the consumer will have in their ability to conduct the task. Finally, the sensitivity and recognition of each consumer as an individual will be a measure of the empathy in each service delivery.

2.4.8 Role of Quality in Health Care Services

Walsh (1991) argues that the issue of quality in public service is political. Although citizens have a right to evaluate the quality of the public service they receive, performance measurement and appraisal, as forms of quality control, tend to be internally oriented and intended to control. This view is supported by Smith (1993). Walsh (1991) advocates that the focus of quality in public services should not be one of meeting service specifications, but of dealing with the shifting value structure of society.

Yet the judgement of quality is largely dependent on the climate of the relationship and on the trust an organisation builds with its consumers (Gabbott & Hogg, 1998). Although Ellis and Whittington (1994) acknowledge the influence of age, social class and sex within society as having an influence on individual satisfaction, it is the service specifications that provide a foundation for measuring or evaluating service.

Any improvements or adjustments to service standards must have a platform from which they can develop (Meekings, 1995). Essentially, any system specifically developed to judge the quality of health care needs to take account of the providers, the purchasers and consumers (Paterson et al, 1991). The requirements of the consumer in terms of expectations and service quality must, therefore, be established and offset with the available provision in order for the exchange to be evaluated positively.

2.4.8.1 Inseparability

The nature of the provision of health care service is such that the care, empathy and sensitivity given by health care professionals is simultaneously produced and consumed. This, as previously outlined, is a distinguishing characteristic of a service. With the inseparability of the service inextricably linked to the perishability

process, supply and demand for a service can affect the overall evaluation of the encounter. Women, for example, using the maternity provision during a busy period simply cannot receive the same attention as women using the service during a quiet period. The staff/patient ratio would dictate the availability of provision in this situation. As the service is perishable it cannot be produced and stored for consumption.

2.4.8.2 Heterogeneity

Patients repeating the service encounter are subject then, not only to the heterogeneity of the service provision but the variability of the service as a result of the specific time period in which it is consumed. Continuity of care for women using the maternity provision is encouraged (Murphy-Black, 1993), yet the reality of heterogeneity and perishability is such that personnel turnover, holidays and absence ensure inconsistencies in provision. Chase (1978), notes that services with higher or longer customer interaction are more susceptible to inseparability and variability.

2.4.8.3 Ownership

The patients will own the benefits of their treatment. Walsh (1991) observes that much of the work of the public sector is preventative, particularly in the case of health or social care. Therefore, the quality of the work that has been done, given that the output may be something that has not happened is very difficult to evaluate. Ownership as a tangible benefit of health service may then manifest itself as information and knowledge. This is particularly true when the treatment or benefit of the service has been preventative.

Yet, the extent to which the end user wants ownership or responsibility for their care is questionable. Recent figures show that approximately 70% of patients leave the selection of hospital entirely at the discretion of their physician (Elliot, Hall & Stiles, 1992). This demonstrates that patients place differing values on benefits and

the climate of the relationship between the patient and provider will be shaped by the value the patient places on ownership.

As end consumers are using the service out of necessity rather than choice, their resignation of responsibility may be pertinent. Zeithaml (1981), Vandamme, and Leuins (1993) also discuss the abdication of responsibility by consumers in certain service sectors because of the technical or specialist nature of the topic area. Credence, therefore, features in the service provision of health care.

2.4.8.4 Credence

Dotchin and Oakland (1994) discuss the credence properties of particular services. That is, whether an individual using a service will have the ability to question or contribute to the service provision. Although a patient may not be aware of the technical aspects of medicine, Cave, Copely and Hanney (1995) comment that the patient will have the ability to express opinions on the various dimensions of "hotel" services that a hospital provides.

The patient, however, should not necessarily expect to have a standardised service from the health care professionals who have to assume the responsibility for care. Goyert et al (1989) found, for example, that the single most important variable influencing the rate of caesarean section was the individual obstetrician involved. Despite the opportunity for ownership, heterogeneity as a distinguishing characteristic of health care and services per se, further complicates the measurement of evaluation of service provision by individuals.

2.4.9 Dimensions of Service Quality

Elliott, Hall and Stiles (1992) identify three dimensions of service quality for hospitals:

- Institutional Quality
- Physical Quality
- Interactive Quality

The institutional and physical qualities are measurable as they are tangible and are likely to be evaluated by the patient as either a result of previous experience in hospital or previous experience in a similar environment (Meekings, 1995). The interactive quality, however, will inevitably be more difficult to measure as individuals give and expect different levels of empathy, sensitivity and caring. Women, for example, have higher expectations of service than men do, whilst those with less education perceive the interpersonal factor and capabilities factor to be less important than do those respondents with more education (Elliott, Hall and Stiles, 1992).

Proctor and Wright (1997) observe that although services are complex and diverse in nature, there are common features which may not be as infrequent as first supposed. The distinguishing characteristics of inseparability, intangibility, perishability, heterogeneity and ownership are common throughout the service sectors and invariably barriers to achieving service quality and improvements within services are widespread. Lack of visibility, accountability, timeframes and uncertainty with delivery have been observed, as obstacles to service quality improvements and these, similarly, are commonplace.

The following section continues with the theme of services whilst concentrating on the aspects of quality, satisfaction and behavioural intention.

2.5 QUALITY, SATISFACTION & BEHAVIOURAL INTENTION

2.5.1 Defining Service Quality

A common understanding of quality is necessary if it is to be assessed, or if quality improvements are to be made. As quality often has a different meaning for different people, concentrating on a recognised or agreed definition is more likely to focus personnel and provide quality of service.

Although many definitions of quality have been suggested, it is possible to classify the definitions into five categories (Ghobadian, Speller & Jones, 1994):

2.5.1.1 Transcendent Quality

A *transcendent* definition of quality is one that discusses the service or product in terms of excellence. The difficulty of accepting this definition arises as the concept of quality has two basic elements, the product itself and the relationship of user and product (Walsh, 1991). That is, as the determinants of quality have not been previously identified, the definition of excellence has little practical use.

2.5.1.2 Product Led Quality

Product led definitions of quality focus on measures of "goodness". Quality service will contain more levels of goodness than a poor service. As such, a service will have to be measurable in terms of units, resulting in the search for tangible attributes. However, a service may be perceived as being of better quality because it meets the customers' demands and expectations as opposed to having a specific number of attributes.

Comparing a hospital birth and a home birth demonstrates the difficulty of using a product led definition. With a hospital delivery, there are likely to be more tangible attributes to measure. These would for example, include a delivery suite, high technological equipment and pain relief. Yet, if a woman perceives the home birth of her second child to be of a higher service standard than that she received during a previous hospital delivery, it may not be attributable to measurable tangibles. Rather, it is likely that the home birth met the expectations of the women using the service.

2.5.1.3 Process or Supply Led Quality

Process or supply led definitions of service quality invariably consider the conformance of a product or service to pre-set requirements. The focus of quality in a process definition is internal as opposed to external and may be useful where a product or service is standardised. The importance of the definition lies in the significance of the role of process in the quality outcome. Although this definition is best suited to standard services with low or short consumer involvement, it is interestingly the main area addressed by the Citizen's Charter.

2.5.1.4 Customer Led Quality

An external focus is one associated with *customer led* definitions of quality. Organisations must determine the requirements of the consumer and meet their specifications to follow this approach. Typically, the requirements will be built into the service at the design stage and, as such, a degree of conformance, which includes the supply-led approach, is established. This definition of quality is most appropriate for intensive, high contact services where knowledgeable personnel are often necessary to fulfil requirements.

2.5.1.5 Value Led Quality

Finally, a *value led* definition of quality is one which meets the requirements of the customer whilst remaining within the confines of a budget. Although the focus is external, the practical application of the approach suggests that there is a trade-off for the purchasers and consumers between quality, price and availability. This is further discussed by Gabbott and Hogg (1998). Reaching a particular market segment may be appropriate using this particular approach.

Measuring the quality or value of a service is in itself complex, regardless of the approach taken to evaluate it. This is simply because service is intangible. Meister (1990) argues that consumers have expectations of quality and that quality is judged by their perceptions of these expectations. To compound the situation, consumers and producers have differing abilities and rights in the assessment of the quality of goods and services (Walsh, 1991).

Common ground does however, exist as the majority of definitions focus on customer led quality. To determine the requirements of the consumer and provide the service specifications, each provider must focus on tangible aspects of the service that are observable and quantifiable (Ghobadian, Speller and Jones, 1994). Even within this framework, difficulties arise, as Carman (1990) observes, consumers of health care evaluate aspects of their service differently.

2.5.2 Health Care Quality and Satisfaction

As health care is not evaluated in a standard fashion, the provision of treatment, the way in which information is communicated and the heterogeneous care of the medical professionals may be considered separately. Yet, the potential for trade-offs is apparent in the overall exchange. If, for example, the nurses were caring and sensitive and the patient was fully aware of the treatment and possible side effects, the lack of coffee in the waiting room may be overlooked. Overall, the service would be perceived as one of quality.

Is service quality, then, merely that the consumer is satisfied? The relationship between quality and satisfaction has been the basis of considerable academic discussion (Gabbott and Hogg, 1998) with Bitner (1990) and Bolton and Drew (1991) suggesting customer service precedes service quality. Perhaps service quality is a general view or an overall perception of satisfying or dissatisfying experiences?

Cronin and Taylor (1992) emphasise the importance of the distinction, as service providers ought to be aware of whether their focus is one of satisfaction or service quality. It is, however, possible to imagine good quality service that may be dissatisfying to the consumer. The number of antenatal check up visits for low-risk women in their second or subsequent pregnancies may be considered "good quality", but may not be satisfying for the consumer.

Taylor (1994) considers the constructs of satisfaction and service quality to be a source of confusion for academics and practitioners alike. Parasuraman et al (1994), Cronin and Taylor (1994) and Teas (1994) continue to debate the most appropriate methods for assessing service quality or satisfaction.

Bitner and Hubbert (1994) identify the main difference between the constructs as satisfaction being applicable to a transaction specific experience with service quality generally being considered as a global evaluation of a service experience. Other differences, however, are apparent (Bolton and Drew, 1991) when satisfaction is viewed as a subjective feeling which results from a service experience and quality is considered as a cognitive evaluation (Bitner etal, 1990). This cognitive evaluation is informed by feelings of satisfaction and, therefore, in this context, feelings of satisfaction precede perceptions of quality. Conversely, Smith and Houston (1983) and Kotler (1988) predicted that overall consumer satisfaction with a service would be positive and substantial when the consumer perceives "high service quality".

Another explanation of the satisfaction construct is provided by Donabedian (1980, 1982, 1992). He theorized that quality of care can be evaluated from structure, process and outcome with satisfaction as *one of a number* of outcomes of quality. Other outcomes would include health status.

Operationalising expectations for the constructs of satisfaction and service quality also indicates a significant difference. Whilst satisfaction is considered to have a predictive expectation (something *will* happen), service quality is associated with a desired expectation (something *should* happen).

Research to associate the constructs are limited. Woodside, Frey and Daly (1989) linked service quality, customer satisfaction and behavioural intention finding that overall customer satisfaction with the service encounter appears to be a moderating variable between service quality and behavioural intention. However, the debate on the constructs of service quality and satisfaction are largely unresolved, with Parasuraman, Zeithaml and Berry (1994)calling for research into an integrative framework, which considers both satisfaction and service quality.

2.5.2.1 Service Quality Evaluation

The gap model of Parasuraman, Zeithaml and Berry which operationalises service quality in terms of expectations and perceptions (Dion, Javalgi & Dilorenzo-Aiss, 1998) has been compared with other frameworks [For example see: Teas (1994) and Cronin and Taylor (1992, 1994)] with some authors scrutinising and criticising a number of issues relating to service quality evaluation, conceptual difficulties and methodological problems. As Parasuraman, Zeithaml and Berry have assumed the role of the American school of thought on service quality, Gronroos represents the most productive researcher in the Nordic school of service quality evaluation.

Gronroos (1984) argues that service quality comprises three dimensions:

- Technical
- Functional
- Corporate

Essentially, the actual outcome of the service encounter can be measured, using the technical dimension, in an objective manner by the consumer. The technical outcomes, for example, of in-patient health care, would be the availability of a bed on an appropriate ward, the correct information for treatment and the smooth debriefing of the patient. These are all observable elements of service quality and can be viewed objectively.

The functional dimension of service quality is more subjective. That is, should the information required for treatment be incorrect, the interaction between the consumer and the provider is less objective. The service quality in this instance would focus on the courtesy shown to the patient, the environment in which the patient is expected to correct the information and the reasonableness of explanations provided for the discrepancy.

Finally, the corporate dimension of the service encounter is concerned with the consumers' perceptions of the service organisation. This overall perception will be dependent on the technical and functional attributes of service quality in addition to external communications and physical location.

Perhaps a more appropriate model for measuring service quality in health care is that provided by Lehtinen and Lehtinen (1991). Their model suggests that service quality also has three dimensions but that these dimensions are physical, interactive and corporate. As such, the major focus of evaluation would be on the condition of the buildings and equipment (physical), the image and profile of the organisation

(corporate) and the relationship between the provider and the consumer (interactive).

2.5.3 Patients' Perception of Quality and Healthcare

Donabedian (1988) suggests that patient satisfaction should be considered as a desired outcome of care. As patients are integral to the overall perception of their care, the way in which they perceive or evaluate the service is paramount in monitoring and improving healthcare. As previously established, the evaluation of quality is difficult, as consumers may value different attributes of care and may be unsure of how to evaluate certain technical elements of treatment.

Market researchers distinguish between customers' satisfaction with respect to specific transaction and their global evaluation of a service (Holbrook and Corfman 1985, Olshavsky, 1985). Consequently, satisfaction can be considered to influence the customer's evaluation of service quality, purchase intentions and behaviour (Bolton and Drew, 1991). Brant (1992) suggests that if quality is to be defined as the extent to which patients' needs are met, then only approaches that are specifically designed for the individual will deliver quality standards.

To measure customer or patient perception of satisfaction, most studies appear to use discrepancy theory (Turner and Pol, 1995). That is, satisfaction is the perceived discrepancy of what the patient desires and what he or she actually experiences. The customer satisfaction/dissatisfaction literature demonstrates that expectations and perceptions of service provision affect customer satisfaction directly as well as indirectly. This is as a result of disconfirmation (Bolton and Drew, 1991).

Clearly, if patients are using service provision for the first time, or have not used the service over a long period of time, expectations may be irrelevant, unrealistic or fairly superficial. Whilst there is evidence to suggest that patient's expectations

and values are involved in evaluations (Linder-Pelz, 1982; Thompson, 1986; Vuori, 1991 and Williams, 1994) they do not appear to be related in any simplistic form. This may be as a result of the modification of expectations throughout the service transaction and, as such, may affect overall evaluation. Perceived value then, evolves from a series of inputs, not least disconfirmation, expectations and actual performance (**See 2.6**).

2.5.4 Behavioural Intention & Attitudes to Intention

Several other studies have considered the relationship between service quality and behavioural intention. Parasuraman, Zeithaml and Berry (1988) and, more recently, Boulding et al (1993) found correlation between positive service encounters and willingness to recommend. Headley and Miller (1993) observe that perceived higher service quality will generate favourable intentions, including repurchase, and that perceived lower service quality correlates with complaining, switching and non-use of any product or service.

Customers' assessments of service value are hypothesised to influence purchase intentions and behaviour (Bolton & Drew, 1991). Techniques for deriving consumer valuations and behaviour are a concept explored by Cave, Copley and Hanney (1995). The method used for their research, a contingent valuation approach, is identified for application and, although difficulties in applying the method are met, the importance of establishing behavioural intention is highlighted.

2.5.4.1 Theory of Planned Behaviour

Behavioural intention and the internal and external influences affecting intention are discussed by East (1992) as he extends the theory of reasoned action first developed by Ajzen and Fishbein (1980) and the theory of planned behaviour (1985) further developed by Ajzen.

The theory of reasoned action assumes an individual:

(1) Has limited knowledge of outcomes and only utilises some of the known variables when intending to consume a product or service

(2) Is largely influenced by members of his/her social group and displays normative behaviour

(3) Seeks personal gain but rarely realises his/her preferences

The theory of reasoned action only focuses on intention as it is acknowledged that external influences have the potential to change behaviour.

The more recent theory of planned behaviour (See Figure 2.1) proposes that there are three types of belief an individual has when he/she intends to act:

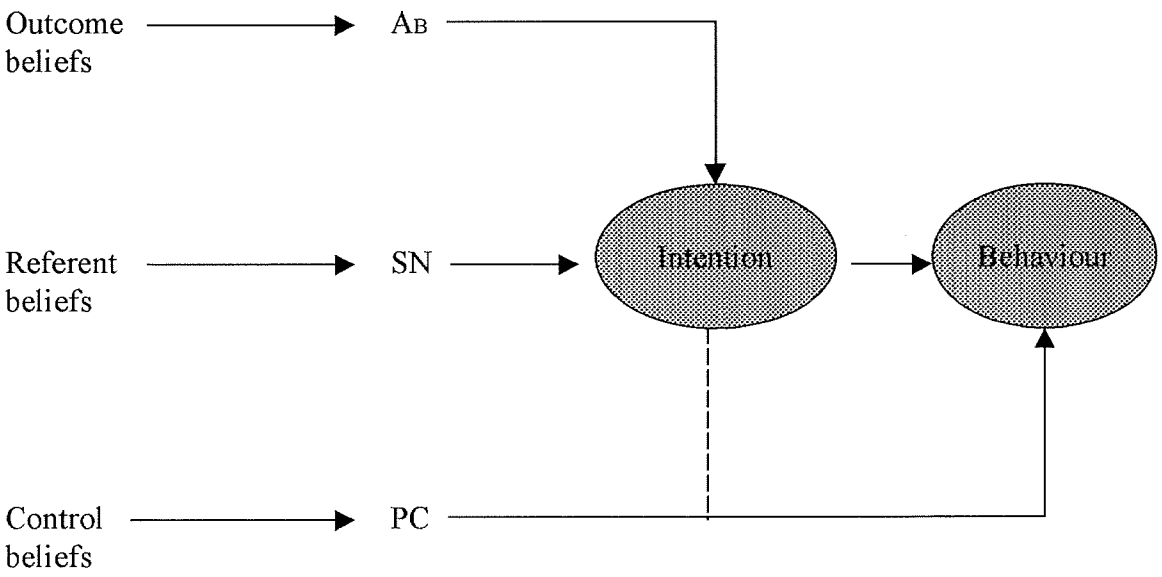
(a) The expected benefit of the product

(b) What other people/groups think they should buy

(c) How easy or difficult it is to access the product

An application of this theory applied to the health care provision is particularly applicable to this study. Ajzen (1988) describes the study Manstead et al (1983) conducted on women intending to bottle feed and women intending to breast feed. They considered the behavioural beliefs and outcome beliefs of breast feeding and bottle feeding.

Figure 2.1 Ajzen's Theory Of Planned Behaviour (1985)



The research involved asking women about to give birth to provide two measures: their subjective probabilities that a given feeding method is associated with the cited consequence, and their evaluation of that consequence. Bottle feeding, for example, would allow the partner to become involved in the feeding routine, whilst breast feeding provides trouble free, inexpensive, complete nourishment for the baby.

Manstead et al also considered the normative beliefs of the women. That is, how the women perceive others in their social or *referent* group expect them to behave. The groups for Manstead's research were identified as: the baby's father, the woman's own mother, closest female friend and medical adviser.

The results of this study indicated, in terms of intention and behaviour, that although all women tended to agree that breast feeding establishes a close bond between mother and baby, those who held the belief more strongly were likely to choose the breast feeding method. Conversely, a woman who believed that breast feeding is embarrassing for the mother or limits her social life is less likely to use this method.

Additionally the normative beliefs of the women were significant. Mothers who used the breast feeding method indicated that important referents strongly preferred this method over the alternative bottle feeding method. In contrast, women who believed that their referents had no strong preferences for either method were more likely to bottle feed their babies.

A woman was very likely to be motivated to comply with normative beliefs if they belonged to the father of the baby and were moderately inclined to comply with the normative beliefs of their own mother and their closest female friend. Mothers, however, who eventually decided to breast feed their babies were highly motivated to comply with their medical advisers than were mothers who decided to use the bottle.

The application of this theory to patients utilising the health care services is both significant and relevant. The use of referent groups and the importance placed on them by users of the provision is important for communicating information regarding appropriate care and may also have a direct influence on both intention and behaviour.

Considerations for influencing intention and behaviour are complex in the health service as normative behaviour for patients is twofold. Primarily, behaviour can be recognised in a hierarchical structure as observed by Green, Coupland and Kitzinger (1990). They highlighted that women who want to be in control of their labour have to adapt their behaviour so as not to antagonise their caregivers. Secondly, normative behaviour can be recognised in terms of equality. Bitran & Lojo (1993) observe that if customers perceive they have been treated unfairly relative to other customers, they can become infuriated.

Repeat purchase or intention to re-use the service may appear less important in the health service context than intention to consume private products or services. However, satisfaction with an overall experience can be beneficial. A client's satisfaction with an experience should have a positive effect for the next service encounter (Bitner, 1990) with poor word of mouth and necessity to provide service recovery being a likely consequence of dissatisfaction.

Donabedian (1992) describes patient satisfaction as a structural feature of health care as he considers a positive experience to motivate patients to seek care and to collaborate in enhancing its success. The importance of measuring satisfaction, including continuing with treatment and developing a physician patient relationship, is discussed (See **2.2**).

If satisfaction is not addressed, behaviours that might indicate dissatisfaction include:

- breaking appointments
- ignoring instructions
- changing doctors

Moreover, these behaviours are central to monitoring patient satisfaction and service quality. Patients, when asked if they are satisfied with their care, are unlikely to provide an answer with depth if they expect the answer to make little difference (See **2.2.4.3**) and, therefore, monitoring *behaviour* may provide greater indication of dissatisfaction. Indeed, the rationale for patient-based service quality research is that patient perceptions of, and satisfaction with, service quality affect intentions (Woodside, Frey & Daly, 1989).

Peyrot, Cooper and Schnapf (1993) observe that patient satisfaction and service quality is enhanced when patients know what to expect. The reason for this is that a reduction of uncertainty minimises stress. The following sub-section concentrates on expectations, the external and internal factors affecting expectations and the role expectations have in enhancing or detracting from performance and satisfaction.

2.6 RELATIONSHIP BETWEEN EXPECTATIONS, PERFORMANCE & SATISFACTION

2.6.1 Values, Cultural Norms and Expectations

Before exploring the concept of expectations and their significance, the changing social context in which expectations are developed ought to be established. Whilst

cultural values are transforming, traditional roles are disintegrating and family units are unrecognisable in comparison to the 1960s and 1970s. A rise in the number of single parents, the increase in the divorce rate and the role of women as carer and employee provides depth and scope for understanding the rise of quality issues in the maternity provision.

2.6.1.1 The Changing Social Context

Oakley (1991) identifies the period from the early 1970s to the late 1980s as the era of the consumer movement in maternity care. Pressure groups, including the Stillbirth and Neonatal Death Society, were set up in an effort to recognise the importance and significance of childbirth as a major life event. In an area where there has been much debate and controversy in both medical and lay circles (Zander and Chamberlain, 1984) health and social services resourcing remains a contentious issue and public accountability continues to be discussed (Walsh, 1991; Smith, 1993; Wheeler & Proctor, 1993).

Issues for the actual and potential obstetrical patients contribute to the overall concern for service quality in healthcare provision. Some of these issues are outlined below:

- Three quarters of potentially poor households are moved out of poverty by women's earnings
- Without changes in social policy women's unequal burden of caring work will intensify in the 1990s
- There are proportionately more births among older women
- 90% of all lone parents are women (Coote et al, 1990)

Pregnancy, then, is a social relationship (Oakley, 1991). Although childbirth is decreasing in western society, the interest and concern over provision and

education in this area has not declined. The opinions of obstetrical patients have been the basis of a number of reviews and initiatives, including the Provision of Maternity Services in Scotland (1993), and as such their expectations and perceptions have provided a platform on which some of the provision has been developed (See **2.7.3**).

Having established the social context in which the maternity provision operates, it is apparent that expectations and quality issues are influenced by external and internal influences. As Williams (1994) suggests, patients might have a complex set of important and relevant beliefs that cannot be embodied in terms of expressions of satisfaction. These beliefs, and expectations developed through these beliefs, are likely to be influenced by cultural and normative values (See **2.6.1.4**).

2.6.1.2 Defining Expectations

Expectations are a result of acquired information from both the environment and the individual's memory. It is a summary of what is known about the likely service experience (Gabbott & Hogg, 1998). Expectations are always concerned with future behaviour (Clow & Beisel, 1995) and, as such, they are forecasts or predictions. The importance of expectations, how they are formed and the way in which organisations seek to meet them have been a forum for debate [See for example: (Parasuraman, Berry & Zeithaml, 1991; 1993; 1995, Clow & Beisel, 1995, Powers, 1988; Green, Coupland & Kitzinger, 1990; Green 1993; Swartz & Brown, 1989)].

2.6.1.3 The Concept of Expectations

The concept of expectations, however, is not universal as expectations have a different meaning for authors between and within satisfaction and service quality studies (Liljander and Strandvik, 1992). The differences occur as the role and

significance of expectations vary between studies and their predictive nature for behavioural intention has been questioned with varying results (Boulding et al, 1993; Williams, 1994; Clow & Beisel, 1995; Green, 1993; Bolton & Drew, 1991).

Boulding et al (1993) assume that an individual's perception of service quality is a blend of prior expectations and the service experience itself. If the individual has no prior experience of the service or product, expectations can still be formed through sources of information. These include:

- prior exposure to the service
- word of mouth
- expert opinion
- publicity
- communications

This is supported by Swartz and Brown (1989) as their research indicates that expectations seem to result from an individual's past experience as well as any communications he/she has received in relation to the product or service. However, Kahneman & Miller (1986) question experience itself as the retrieval and/or construction of experience is prone to variations. Depending on the normality or abnormality of an event, the permeation of experience may vary.

2.6.2 Past Experience and Expectations

The role of experience in the developing of expectations appears to be central as John (1992) observes that consumers' previous experience in a product category shape their expectations in that category. Behavioural intention has been closely linked to positive experience and future expectations or intentions (East, 1992; Bitner, 1990; Powers, 1988; Clow & Beisel, 1995) whilst Woodside, Frey & Daly

(1989) convincingly demonstrated that overall customer satisfaction with hospital services is associated positively with behavioural intentions to return to the same hospital.

The more experienced the consumer, the more likely the expectations are to be higher (Parasuraman, Berry & Zeithaml, 1991) with experienced consumers more likely to voice their opinion. Consumers who use the service more often than others also have a greater opportunity of experiencing disconfirmation of expectations (Bolton & Drew, 1991).

2.6.2.1 East & Experience

When considering Ajzen's Theory of Planned Behaviour (**2.5.4.1**), East (1992) believed that expected benefits, normative beliefs and control beliefs were most powerful in the field of product use. East considered the relative influence of benefit and normative beliefs in a purchase decision to include not only frequency of use but how socially relevant the product was and the influence of what others would expect when an individual made a purchase.

East (1992) categorises types of consumers on the basis of their experience. The novice consumer is a first time buyer, with the expert consumer having previously consumed a product or service. Novice buyers arise when either the product or the consumer is new to the market. There are also new buyers for established products including alcohol or nappies.

In many markets new buyers are quite a small proportion of the total number of buyers. Wilkie and Dickson (1985) in a study of white goods purchased in the USA found that at least two thirds of the purchasers had made the purchase before.

New buyers also enter the product life cycle (PLC) at different stages of the buying cycle. Where the product life cycle has the following stages: introductory, growth, maturity and decline, a new buyer may not buy the product during the introductory phase. East (1992) indicates that if we understand the differences between the thinking of novice and expert buyers, a better knowledge of how products should be developed and promoted over the course of the product life cycle will be the outcome.

East's initial research (1990) involved ascertaining the determinants of intention for experienced and inexperienced people by considering students purchasing a computer. The students in East's study making a first time purchase were more affected by the views of parents, other students and staff. This supported the research conducted by Knox and De Chernatony (1989) on the heavy/light drinking of mineral water. Knox and De Chernatony concluded that the non-user is characterised more by the influence of social norms whilst the heavy user shows less reliance on these influences.

East's research hypotheses was then that novices, because of their unfamiliarity with the service, would utilise referent groups to a greater extent than experts. Additionally, novices would be inclined to conform to social norms because of their lack of experience. Contrary to this, East hypothesised that experts would use a service based on the benefits they perceived they would gain and were less likely to refer to peer groups, family or friends when making a purchasing decision.

To test these hypotheses, East considered the application for shares in the British regional electricity company, which included a measure of previous experience. As such, the more and less expert investors could be compared. The research was conducted within the framework of Ajzen's Theory of Planned Behaviour with the expected benefits to the buyers including making a profit and transferring funds in order to apply for shares. Referent measures were family, friends and political

parties. Finally, access to funds and knowing how to buy and sell shares were identified as control beliefs.

Having conducted his research, East found the *opposite* to be true of his categorisations. *Novices were less likely to use referent groups and experts were more likely to use referent groups to aid their purchasing decisions.* The key constructs of East's research, therefore, remains experience and knowledge and the significance of types of experience is prevalent in this work.

2.6.3 The Role of Expectations

The function of expectations and their role in determining service quality and overall experience perception in the maternity provision has been considered within the literature (See Green 1993; Kitzinger & Green, 1990) and a strong relationship between expectations and experience has been established. Having defined expectations as information acquired through the environment and through memory, the anticipatory role of expectations is prevalent. The changing of expectations throughout the service experience has been explored and the difficulties of measuring these changes are apparent (See **2.6.1.4**).

As women have forty weeks to prepare and anticipate giving birth to their child, they will form expectations. These expectations may change throughout the period of pregnancy and are likely to be influenced by medical professionals, family, friends and peer groups. If these expectations continually change, their relevance is brought into question. Yet women, on the whole, are reported to experience as much pain in labour "as they expected" (Green, 1993). Indeed, women who found labour to be as they expected were more likely to be satisfied. In these scenarios, expectations are constant rather than variable. Gabbott & Hogg (1998) support this view as they observe that expectations represent enduring wants and needs and as such are more constant over time.

Ideal expectations (Boulding et al, 1993) or expectations which are unlikely to be met are criticised as unnecessarily raising expectations. Authors have considered lowering expectations to satisfy the consumer (Barnes & Prior, 1995; Bennett, 1993; Elliot, Hall & Stiles, 1992; O'Connor & Shewchuk, 1990) and this use of expectations, as a valuable tool for business strategy, highlights the importance of expectations as a way of identifying and satisfying customer needs.

The role of expectations is relevant to the overall perception of the service experience. As customer relationships are central to exceeding customer expectations (Parasuraman, Berry & Zeithaml, 1991) the role, significance and function of expectations is apparent. A variety of expectation "type" has also been explored (See Miller, 1977, Gilly, Cron & Barry, 1983 & Tse & Wilson, 1988) and these variations add depth to the concept and definition of expectations.

2.6.3.1 Types of Expectations

In an effort to know how the consumer compares their expectations against the performance of the product or service, Miller (1977) suggests four types of expectation:

- ideal
- expected
- deserved
- minimally tolerable

Zeithaml, Parasuraman & Berry (1991), whilst considering the perception of the service as opposed to the performance, present the concept of adequate and desired expectations. The adequate expectation of the service is the one being the most likely held by the individual and the latter supporting the satisfaction/dissatisfaction paradigm. Boulding et al (1993) further consider types

of expectations and suggest two possible alternatives; normative expectations (what is likely to happen in the service encounter) and ideal expectations (what would happen in an ideal situation).

It is generally accepted then, that consumers' expectations operate on at least two different levels, and that although other expectation types have been identified, two clear types of expectations are recognised as identifiable constructs. The suggestion that expectations or the perception of a service experience is based on normative beliefs, that is, what appears to be socially acceptable in the current situation (Barsalou, 1983), could also be applicable on these two levels.

Parasuraman, Berry & Zeithaml (1991) observe that customers' expectations of a service are likely to go up when the service is not performed as promised. Similarly, depending on the experience of a consumer in a service situation, the expectations may be adequate or ideal.

2.6.3.2 Managing & Evaluating Expectations

Clow and Beisel (1995) consider managing expectations as critical to the success of service firms. Assessing these expectations may be problematic. Collating data on consumers' expectations has methodological difficulties (See **2.6.1.3**) and questioning customers that remain after a service has deteriorated may also be inappropriate as they may have lower expectations (Bitran and Lojo, 1993). If, however, as Swartz and Brown (1989) suggest, the customers' assessment is significantly influenced by the end result, the crucial period for managing expectations and the perception of the service experience is after the event.

Overall satisfaction of maternity patients was influenced by parity (number of children a woman has) and expectations (Green, Coupland & Kitzinger, 1990) and, as such, the importance of experience and the significance of the perceptions

of antenatal period, labour and postnatal period are central to assessing service quality.

Whilst Tomes & Chee Peng Ng (1995) observe that patients' expectations have risen since the introduction of the patient's charter, the desired level of expectation is considered too high by those providing the service. Unless expectations and perceptions are matched for the service provider and the service user, the level of expectation and the perception of the service may never be appropriately managed. As Zeithaml (1991) suggests, using marketing communications to manage the expectations of the service customer may afford the service provision a consistent and viable goal.

Summary

The second section of this literature review has raised the salient issues of satisfaction, service, service quality, behavioural intention, experience and expectations.

Initially satisfaction, its importance and relevance in health care was discussed with the methodological difficulties in assessing satisfaction being raised. Service and its properties were addressed and the difficulties associated with evaluating service were considered. Service quality was contextualised, with types of quality and the applicability of service quality to the health care sector discussed. The differences, similarities and overlapping of the constructs of service quality and satisfaction were discussed before considering patients' perception of health care and the significance of patient evaluation of health care.

Behavioural intention and attitudes towards behaviour, as a result of no/previous buying experience were considered. The theory of planned behaviour and the influence of subjective norms (referent groups), outcome beliefs and control beliefs were also described, with the application of this theory to the maternity sector

discussed. East's (1992) categorisations of novice and expert were explored with individual experience and expectations considered as a way in which to manage the evaluation of the "service experience".

The following section considers the maternity provision, its' role in health care and the evaluation of the provision by users' (patients). Key service issues, expected outcomes, areas of discontent, the developing of expectations through informal support groups and social and cultural diversity are discussed to provide further scope for the context of the primary research.

2.7 MATERNITY SERVICES WITHIN THE NHS

As detailed in the initial section of this literature review, the Patient's Charter, published in 1991, outlined the commitment of the government that the NHS should, in their service provision, be responsive to the needs of the user. In Scotland, in April 1992, a Framework for Action Working Group on Maternity Services was formed to examine the provision for obstetrics by consulting users and staff and to develop strategies for raising standards (CRAG/SCOTMEG, 1995).

Although a great deal of emphasis has been placed on Changing Childbirth, the English version of the Policy Review Document, the same principles and aims are outlined in both sets of guidelines for maternity provision.

2.7.1 Maternity Provision

Essentially each individual user of the maternity provision will experience three stages within the overall process: the antenatal stage, labour and the postnatal period. At each stage of the process, an individual technically has many options and decisions to make, although decisions for the labour and the postnatal period e often made during the antenatal stage. These are detailed in **Table 2.2.**

Antenatal Period	Labour	Postnatal
- Place of birth -home -hospital ⇓ consequences for type of care - Antenatal screening for abnormalities ?risks ?consequences	Epidural pain relief more likely to need - forceps - caesarean - suction cup Breech presentation - turning - normal delivery - caesarean	Bottle/breast feeding - mixing - health aspects - IQ of baby - cot death - expense

Table 2.2 Summary of User Choices in Maternity Services

However, it must be recognised that many of the options and choices outlined in the Policy Review Document relates to low-risk women. Low risk women are those considered to be less likely to suffer from perinatal mortality, preterm delivery, intrauterine growth retardation or a low apgar score (indicates the health of the baby by taking a number of factors into consideration) at birth. High risk women are expected to be more pre-disposed to these difficulties. Although there is no reason why the key principles of good practice cannot also apply to high-risk women, their care will inevitably be more specialist-led. This obviously leads to limitations in decision making and choices for women considered to be high-risk.

This reduction of choice is disconcerting if the findings of an examination of the current methods of risk assessment are accepted (CRAG/SCOTMEG). This study revealed poor predictive value in identifying high and low risk women, with a high rate of false positives. That is, women considered high risk and therefore limited in

their choices for childbirth, were sometimes subject to investigations, interventions and unnecessary anxiety.

2.7.1.1. The Changing Environment

Since 1945, there have been a number of reports on the service provided by the health care service for obstetric care. In 1957 the first report on Confidential Enquiries into Maternal Deaths in England and Wales (HMSO) detailed the continuing difficulties women were experiencing during their labour and postnatal period. The study revealed that women were at risk from haemorrhage, sepsis and lack of availability of operative facilities (Beard 1992).

The Cranbrook Committee, which reported in 1959, favoured an increase in the proportion of hospital deliveries to 70%. The above findings prompted further limitations on place of birth when, in 1970, a report of the sub-committee of the Standing Maternity and Midwifery Advisory Committee recommended that facilities should be provided to allow 100% hospital delivery (Peel, 1970).

As a result of these recommendations, the medicalisation of pregnancy from home birth to hospital confinement, transformed the way in which women were to deliver their children. It was also accepted that those women with normal pregnancies should forego the benefits of delivering at home in order to ensure the safety of the majority whose lives were at risk by unpredictable obstetric emergencies (Beard, 1992). This trend had particular relevance in Scotland where, because of the geographical spread of the population, there had been many small general practitioner maternity units (Murphy-Black, 1992).

2.7.1.2 Increased Intervention

With women delivering in hospital, the potential for intervention to increase was evident (Oakley, 1980). Additionally, the shift from local authority control to one

of increased centralisation led to an overall reduction in individual treatment (Beech, 1985).

Yet the importance and role of the midwife, further to the significance of the continuity of care, was acknowledged. The re-organisation of the NHS in 1974 developed the management structure with the integration of midwives into the overall system. Midwives were to attend all matters relating to midwifery policy and practice (SHHD, 1973).

2.7.2 Continuity of Care

In 1980, the Short Report recognised the difficulties faced by practitioners in providing continuity of care (Social Services Committee, 1980) but considered that this care could be achieved through efficient organisation. The Short Report also recommended that home births be phased out with a recommendation for more community based care.

Developments during the 1980s attempted to address the issue of fragmentation of care. The team approach, where a limited number of midwives were to provide care, throughout the maternal process to a limited number of women, was recommended (Maternity Services Advisory Committee 1982-1984) with the Royal College of Obstetricians and Gynaecologists (RCOG, 1982) and the National Childbirth Trust supporting these developments.

Despite an increase in the safety of maternity services with a progressive decline in perinatal mortality between 1975 and 1990 from 19.3 to 8.3 per 1000 births (Beard, 1992) and a sharp decrease in the number of maternal deaths, Beech (1985) highlights discontent over the provision of care.

The areas of discontent can be briefly summarised as:

- locus of control being with caregiver
- use of intervention without adequate consultation or consideration
- attitude of caregiver being negative

(Green, Coupland & Kitzinger, 1990)

2.7.2.1 Key Issues for Users of the Maternity Service

If the locus of control, use of intervention and attitude of caregiver are areas of discontent for users of the maternity services, existing literature is specific and varied regarding what women actually want from their caregivers and the service provision [For example see: Alexander, Sandridge & Moore, 1993; Ball, 1987; O'Meara, 1993; Lumley, 1985; Jacoby, 1987; Green, 1993 & Drew, Salmon & Webb, 1989].

Women would like their midwives to be the first point of contact in pregnancy, with all the options of locally available service provision being discussed. Obstetric service users generally want to spend time with midwives during their pregnancy and want these caregivers to provide total antenatal care, unless high risks are identified in the individual being cared for. Additionally, midwives are sometimes seen as a "buffer" between the mother and the obstetrician, with the midwife being viewed as supportive towards the mother where the obstetrician is being unsympathetic or off-hand (Hutton, 1994).

During the labour period, users would like to be given honest information, support and encouragement with a positive reception to the labour suite. Ideally, midwives should stitch episiotomies or tears in preference to a doctor, although the belief in a woman's ability to give birth without intervention is also important (MORI, 1993).

Finally, during the postnatal period women want encouragement, named nurses, help and support with breastfeeding and to choose length of postnatal stay (Hutton, 1994; Beech, 1984;1985).

Key issues for users of the maternity services are available and research in this area has both depth and scope. The question of addressing these issues are considered under the Policy Review Document (See **2.8**) and the difficulties in meeting service requirements are explored.

The informal support groups who are committed to change in this area of provision are detailed below, although barriers to health care involvement have also be considered (See **2.7.3**) as the opportunity to influence health care can be limited.

2.7.2.2 Informal Support Groups

Two informal groups committed to resolving areas of discontent within the maternity services were established in Britain in the 1960s. The first group, The National Childbirth Trust, widely known as the NCT, is an organisation which concerns itself with preparation for and education in childbirth. The second of these groups is known as Association for Improvements in the Maternity Services (AIMS). This is a pressure group committed to campaigning for improvements in maternity care as perceived by the users.

These two groups aim to reduce ignorance and fear of childbirth through the use of support groups and publications. The Working Group on Maternity Services in Scotland cite the NCT as an example of good practice in co-ordinating the approach to antenatal education and information giving.

The NCT provide classes which follow the model of:

- small numbers
- mutual support
- interactive style
- participation of partners
- emphasis on practical techniques

In the 1990s, the key issues for the users of the NCT and the maternity provision continue to be information, communication and choice and continuity of care (CRAG/SCOTMEG, 1995). The following section provides an outline of consumer views on maternity provision, detailing the key issues and considering the opportunities, limitations and barriers for patients to influence service provision.

2.7.3 Consumer Views: Opportunities for Involvement

As competition in the NHS market increases, particularly in a specialised market such as obstetrical services, health care providers must determine new ways to understand and analyse the users of the service (Marshall & Javalgi, 1995). Maternity provision, as opposed to Accident and Emergency departments for example, has the opportunity to develop relationships during the maternity process and across individual experiences. If hospitals want to create a unique image that engenders customer loyalty, repeat purchase behaviour and referral of friends, they must focus on managing relationships (MacStravic, 1984).

The potential advantages for managing relationships within the service encounters are, therefore, apparent. Communicating with users of the service encourages repeat purchase and counteracts post purchase dissonance. However, investigating maternity care is particularly complex because views and experiences of the

services vary not only during the course of pregnancy and confinement but also between one pregnancy and the next (Melia, Morgan, Wolfe & Swan, 1991).

2.7.3.1 Social and Cultural Diversity

In addition to this, the Commission for Racial Equality (1994) note that women from varying social and cultural backgrounds were treated differently during their use of the maternity provision. The ability to articulate needs and wants is undoubtedly a factor in perception of involvement and overall satisfaction. Furthermore, the desire to be involved in health care or take ownership for care is an individual choice.

2.7.3.2 Antenatal Class Attendance

During the antenatal period users of the maternity services have the opportunity to attend antenatal classes. As previously mentioned, the National Childbirth Trust have been cited as an example of good practice for supporting women during the overall process. These classes, however, must be attended to be of use. The NCT indicate that consumers' opportunity for involvement is increasing as a result of information given during pregnancy (North Thames Regional Health Authority, 1995) but, as observed, the opportunity for involvement and information gathering is often limited by attendance of antenatal classes, social diversity and cultural differences (CRAG/SCOTMEG, 1995).

Focusing on established relationships or targeting specific groups may provide an avenue for involvement, communication and information exchange. Typically, all users of the maternity services will have an established or existing relationship with their local general practitioner.

2.7.3.3 Use of the General Practitioner

Smith (1996) conducted a survey in which she questioned the general practitioner's role in maternity provision, continuity of care, satisfaction with care received and the general practitioner-patient relationship. She observed that as a result of maternity care becoming more woman-centred, the role of the GP was likely to be affected. Yet her particular study underlined that most women considered GPs to have an important role in routine antenatal care and that GPs communicated well.

One way, then, to overcome the difficulties noted by the Committee for Racial Equality, would be to encourage patient involvement through existing relationships as well as developing new relationships with midwives.

The importance of involvement, managing relationships and the role of the patient are not issues which can be dismissed. Charles and Curtis (1994) describe "Birth After Thoughts" a postnatal service which was started in response to the concerns of obstetricians and midwives that some women, after the birth of their children, would have some unanswered questions which could trouble them for months or years afterwards. These concerns were also outlined by Kitzinger (1991) who detailed a study conducted on women who had given birth 15-20 years previously. All the women recalled, often with great clarity, the way the doctors and nurses behaved and the things they said.

Each birth, therefore, is simply not concerned with the mechanics of delivering the baby but the creation of an intense memory and on-going relationship. The potential for involvement is available but barriers to taking the opportunity to become involved have to be considered in terms of social and cultural diversity and heterogeneity. Inevitably, the management of the health care relationship will affect future behaviour intentions and information, sought informally, by family, friends, peers and colleagues. As such the role of users of health care in achieving

a quality service is a salient issue not only of this research but of quality in health care as a whole.

2.8 POLICY REVIEW DOCUMENT

In the Policy Review Document (HMSO, 1992), the Provision of Maternity Services in Scotland has been considered, taking into account the views of women themselves and with particular reference to the Patient's Charter (1991).

As a result of this document, an action plan for implementation was produced, with the following recommendations, to provide a platform for maternity provision in Scotland:

- greater recognition should be given to the role and teamwork of the professionals - as well as considering the central role of midwives
- women should be given full information to enable them to make an informed choice
- purchasers & providers should consider less centralised, low-tech maternity care
- flexibility regarding the postnatal period should be approached

As such, users of the maternity services should expect to be able, with adequate information, to choose a delivery option, continuity of care and carer and communication. Low risk women can be supervised throughout the maternity process by a midwife, with women also being given real choices throughout their care which may include a preference for delivery in a specialist hospital. All women should have the opportunity to be seen by a consultant obstetrician at least once during pregnancy regardless of chosen place of birth.

2.8.1 Difficulties in Implementing the Strategy

The Midwives Information and Resource Service (MIDRIS, 1997), observe that the implementation of both the recommendations of the Policy Review Document, and Changing Childbirth, is far from an easy task.

Problems not only occur when there is no clear evidence on which to base choices but when the evidence does not match local practice or policies. There is potential for conflict to arise when caregiver and recipient cannot agree on particular issues of service provision. Unpleasant information may not be given to reduce anxiety. Additionally, the provision for informed choice during an emergency is limited.

Although informal support groups, GPs, obstetricians and midwives have responded positively to the recommendations regarding informed choice, the potential isolation of the midwife, with the exclusion of the obstetrician from normal pregnancy has caused concern (Dunlop, 1993 & Brown, 1994).

2.8.2 Evaluation of Practice

As much of the Action Plan and recommendations are being carried out as part of the performance monitoring process and annual accountability reviews, the performance indicators are already in existence. By their very nature, performance indicators are measurable, with the adaptation of intangible aspects of service quality into performance indicators a challenging prospect.

Further to this, a recent national review of the maternity services (Audit Commission, 1997) indicated that there was a great deal of variation in maternity provision across the country. Clearly some issues remain unresolved, although many women and their partners report positive experiences of childbirth through the use of primary research methods (Hutton, 1994).

Summary

The above section has considered the existing structure of the maternity services provision, demonstrating the changes in the environment whilst focusing on trends within the service. Specifically, it has been observed that hospital births, although common place, are now designed to be more flexible with information, continuity of care and communication the key themes for women and practitioners within the obstetric services.

Although women are encouraged to become involved in their care, research has highlighted that differences in service provision are experienced by individuals from varying social and cultural backgrounds. Regional differences in health care have also been identified.

The Policy Review Document, which considers the guidelines of the Patient's Charter (1991), with regard to the maternity services, has been detailed to provide an indication of what users of the maternity services can expect in terms of provision. Problems with implementing and evaluating the recommendations have also been acknowledged, although it is recognised that users of the maternity services, as well as their partners, have had positive experiences.

The following chapter explores the methodological issues and primary research undertaken for this thesis. It provides arguments to substantiate the use of triangulation of data whilst providing a framework for analysing the collated information.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction to Research Methodology

The previous chapter, which discussed the current literature, established the case for conducting research to identify service issues, expectations, perceptions, levels of satisfaction and the use of referent groups of women using the obstetric services. This chapter considers the empirical research conducted to collate data on these salient issues.

This primary research encompasses three separate studies: focus groups to explore current expectations, in-depth interviews as a further exploratory measure to consider longitudinal issues and a survey to quantify the preliminary research. The aim of this chapter is to demonstrate the correlation between the stages of primary research and to discuss the triangulation of data. Broadly, issues such as objectives, framework and the validity of the research provide a general introduction.

3.2 Research Aims & Objectives

The expectations and perceptions of women using the obstetric services has generated growing interest. This has been observed in parallel by medical professionals and academics in the last decade [See for example: Prince & Adams, 1989; Beard, 1991; Murphy-Black, 1992; Melia et al., 1991, Robinson et al., 1993] and is increasingly attracting academic notice.

Yet, current measurements of consumer expectation, notwithstanding consumer satisfaction, is an area marred with difficulties (See **2.2.4**).

Considerable effort within the public sector has been expended in recent years to ensure the development of a wider range of options for service provision and the need to consult users' views as an input to decision making (Barnes & Prior, 1995). Yet consumerism can disempower public service users (Dowding, 1993) as the trouble and stress involved in deciding which competing service will provide the best scheme outweighs the advantages of ability to choose. The question of whether consumers expect or want to decide on technical aspects of their healthcare has been raised (Barnes & Prior, 1995).

Developments within this area suggests choice is not a priority for users of the health service. Values of confidence, security and trust, however, remain central. The application of users' expectations to systems of health care would, therefore, provide a positive contribution for the provider and users, building both public trust and confidence amongst service users.

3.2.1 Expectations

Definitions, types and the concept of expectations have been addressed in the context of the literature (See **2.6**). For the purpose of the methodology, types of expectations, the use of referent groups and the use of experience in developing expectations, are central.

As explored in the the literature (**2.6.3.1**) two *distinct* expectation types have been identified: ideal and adequate. Although more expectation types have been identified, for example, minimally tolerable and deserved, the *distinct* types of expectations were used for collecting data to avoid both confusion amongst the respondents and lengthy explanations of expectations types during the exploratory phases of research. Women using the maternity provision typically would have ideal expectations (desired expectations which may be unrealistic in practice but

would be what the women would have if they could choose) and adequate expectations (what is acceptable in a service encounter).

For the purpose of this methodology, establishing the difference between ideal and adequate expectations was to be imperative as the perceptions of the service experience may be positive or negative based on those expectations. The difference between ideal and adequate expectations were established by the use of prompts in the three stages of empirical research. That is, once a woman had expressed her expectations of a particular aspect of her service encounter, she was asked if this was what she would like to happen or if this would be an acceptable level of service if the expectations were fulfilled.

The benefit of establishing the types of expectations, held by the participants of the research, added to the weight of the findings. If, for example, a user of the maternity provision consistently had ideal expectations and poor perceptions of the overall service, the attitude of the user towards the service encounter was identifiable and able to be explained.

Whilst identifying types of expectations, the way in which the expectations were recorded and the experience of the participant responding in a group and one-to-one interview was also considered. Experience of a similar event provides normality to a situation thus reducing the element of surprise. Experienced users of the obstetric services, therefore, may be less likely to be surprised and more likely to have formed expectations based on previous experience.

3.2.2 Experience

The research methodology then, had to consider the effect of experience on the perceptions of the service user to establish if varying degrees of expectations existed between inexperienced and experienced service users. By adapting East's categorisations of novice and expert, the empirical research was able to identify

differences between inexperienced and experienced obstetric service users. The following section explores concept of novice and expert.

3.2.3 East's Categorisations

The broad aim of this research is to examine the expectations of users of the maternity services whilst applying East's categorisations (1992). As such, emphasis is placed upon users' expectations of the maternity services, measured against their actual experience of the approach.

East has two categories of purchasers or users of service: the novice and the expert. The novice is a first time buyer or user of the service, whilst the expert has previously experienced the purchase or service. For the purpose of this research, the experience of service will be the focus.

East initially considered in his research hypotheses that novices, because of their unfamiliarity with the service, would use referent groups to a greater extent than experts and would be inclined to conform to social norms because of their lack of experience. Contrary to this, experts would use a service based on the benefits they perceived they would gain and were less likely to use referent groups to develop their expectations and aid their decisions.

East's categorisations of novice and expert were explored during this study and the experiences of the respondents were considered in relation to their expectations. Novices were identified as first time mothers, with experts being mothers with two or more children. For example, if novices were being asked for their expectations, they would ideally be pregnant with their first child. Experts being asked for their expectations would ideally be pregnant with their second or subsequent child.

These categorisations were examined by:

- The use of mixed parity focus groups (the number of children a woman has had) to assess the differences and similarities amongst the novice and expert participants

- "Before" birth and "after" birth interviews with novice and expert respondents to assess the differences and similarities amongst the novice and expert participants and to substantiate the type of expectations (ideal and adequate) and the fulfilment of the expectations for both novice and expert categories

- Quantitative questionnaires to provide breadth and width to the previous empirical research findings, again using novice and expert participants

A different sample was used for each stage of primary research. Ideally, a longitudinal approach should have been used and each step of the maternity process should be measured. A longitudinal design, although incorporated to some extent within the in-depth interviews, presents difficulties. The transition from the antenatal stage to labour to postnatal period is typically a short and rather sudden conversion, and measurement at this stage was not considered feasible due to practical constraints upon access and user privacy.

The advantages of focusing on women using the obstetric service for this research have been identified (See **2.6.3**) and include the length of time a women has to develop her expectations. However, when considering the methodological design, limitations of considering users' of the maternity provision became apparent. To question a woman during labour on her service encounter would involve securing agreement from the participant and birthing team (midwives, consultants etc.) before the birth and during labour (as the participant may change their mind). Furthermore, the ethics committee may feel it inappropriate for a lay person to be involved at this stage of the maternity process. If the participant is a novice it may

add pressure to a unfamiliar situation and the drugs used to alleviate pain during labour may effect overall service perception.

Therefore, to assess the expectations and perceptions of novice and expert users, a variety of methods was chosen to collect the data with the limitations of a longitudinal approach identified. This chapter considers these methods, their merits and demerits and their appropriateness for measuring the users' views of the obstetrics process.

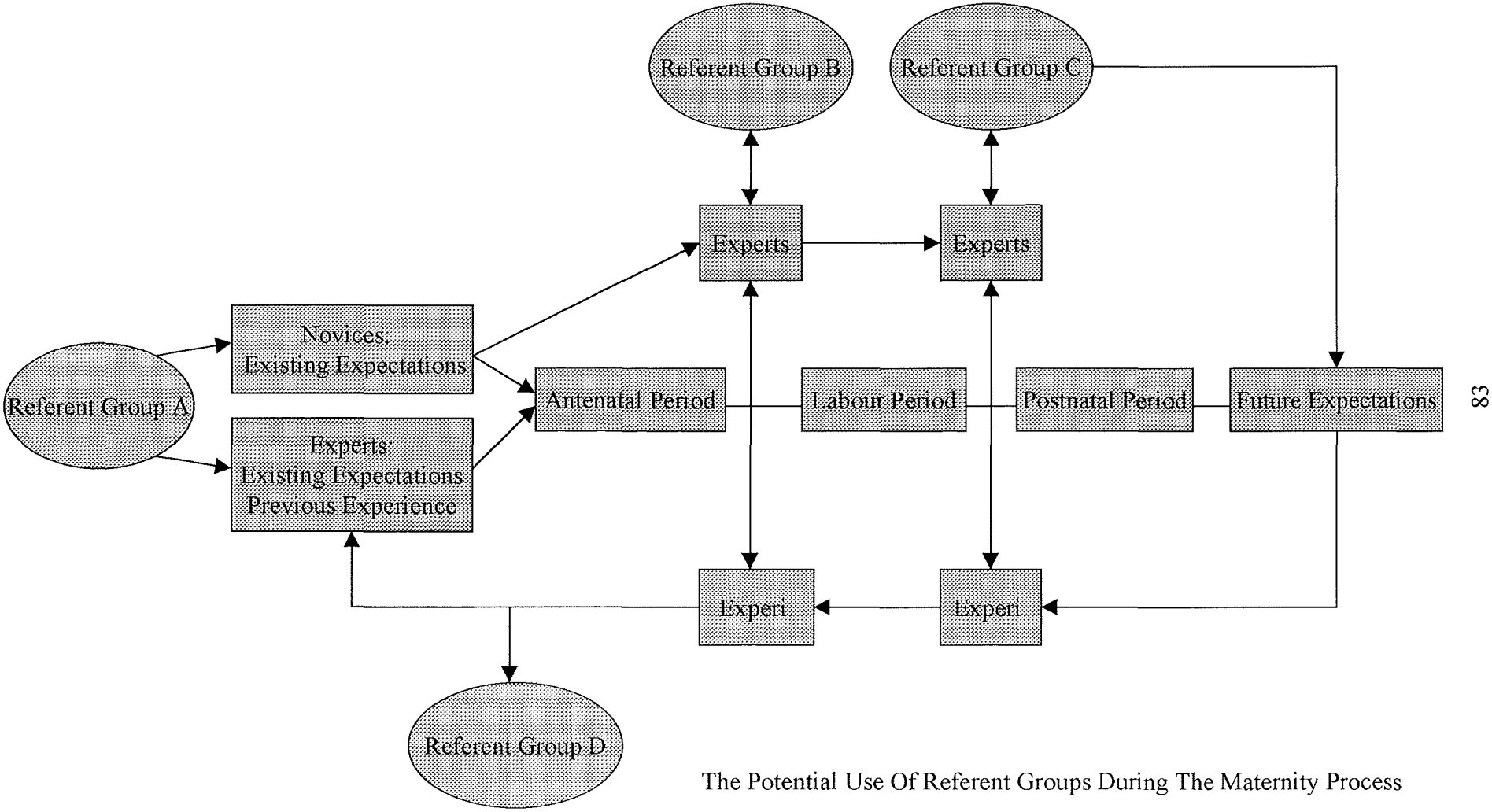
3.2.4 The Choice of Service Provision

The obstetric service has been selected on the grounds that a number of changes taking place in the health sector are widely expected to stimulate an increasing interest in the service provision [See for example: Bennett, 1993; Johnston, Venkat Narayan & Ruta, 1992; Moss, 1992; Maxwell, 1992]. Broadly, the important trends are the current measurements of performance, ensuring quality and cost effectiveness and changes in the nature of consumer requirements.

Previous research in this area has not progressed to utilising categorisations of a consumer behaviour theory to generalise the expectations, and perceptions, of specific categories of maternity provision users.

Consequently, the primary aim of this research was to identify the expectations and perceptions of women utilising the obstetric services using categorisations drawn from East (1992). These categorisations were employed within the empirical research to test both the usefulness and validity of understanding how women's expectations of maternity services develop. As a result, a conceptual model specifically applicable to the maternity sector has been produced (See **Figure 3.1**).

Figure 3.1: Framework Model



The Potential Use Of Referent Groups During The Maternity Process

Three empirical studies were undertaken to establish, confirm and quantify the expectations of women using the obstetric services. The primary objective of the overall research was :

- To identify expectations of users of the obstetric services and to consider if these expectations were affected by experience.

In order to accomplish the primary objective, enabling objectives were also set. The first of these objectives was to establish current developments in setting service provision criteria in the obstetric service. This was to create a grounding in this specific area of research. The objectives, outlined below, were to provide the foundation for the format used during the exploratory focus groups, the in-depth interviews and the quantitative survey. These objectives were:

- To highlight the issues concerning women who had used obstetric services since the implementation of *Working for Patients* (1991)

- To explore the use of formal and informal referent groups and to develop an understanding of the constructs which shape women's expectations and opinions of obstetric services

- To ascertain if expectations are affected by experience, using the variable parity (parity being the number of children a woman has had)

The first of the enabling objectives was to provide an insight into the current levels of satisfaction, or dissatisfaction amongst the users of the obstetric services.

Referent groups, formal and informal, were the important elements of the second enabling objective. Formal Referent groups, for the purpose of this research, are

GPs, midwives, medical professionals and literature. Informal Referent groups, for this research, are identified as family, friends, peer group and colleagues. The significance of referent groups are that expectations are a blend of prior expectations and the service experience itself (Boulding et al, 1993), with influences and influencers potentially changing or developing those expectations.

The aim of the second objective was to identify the referent groups of the sample, the extent to which referent groups were used and to establish the varying degrees of usefulness of these referent groups. An understanding, then, of the shaping of women's expectations and opinions of the obstetric services was to be developed.

Finally, the extent to which experience affected expectations was to be considered. As the sampling frame, throughout the empirical studies, consisted of women from different residential groupings and obstetric users who varied from having no children to those who had seven children, the distinct variables of residential groupings and parity were utilised. The exploration of experience and its affect on expectations was also conducted using "before" and "after" interviews that are discussed within this chapter (See **3.4**).

The focus of this research, then, is on the users of the obstetric services, their expectations, their use of referent groups and finally, the influence of their experience. The following text details the research design which identifies the methods used to fulfil the aim of the objectives. The empirical research conducted in this study was concentrated in Edinburgh and the surrounding towns and villages to facilitate access and reduce time and travelling costs.

3.3 FOCUS GROUP METHODOLOGY

3.3.1 Necessity for Research

Although the current literature available in this area, detailed in the previous chapter, explores the views of the users' of the maternity provision, three significant reasons for conducting empirical research arose at this stage:

- opinions, expectations and perceptions of *current* users of the maternity provision could not be explored in the secondary data

- the categorisations of East's Theory of Reasoned Action had previously not been adapted or employed in research within this area and, as such, the exploration and identification of these types were central to the research objectives

3.3.2 Alternative Data Collection Methods

Having established the necessity for empirical research, the choice between a qualitative approach and a quantitative approach was raised. Initially, a questionnaire was considered at this stage to collate quantitative data on users' opinions and views of the maternity provision. The types of questionnaire available were a postal questionnaire, a telephone questionnaire or a self administered questionnaire.

The likeliest type of questionnaire to have been used would have been a postal questionnaire because of the inevitable limits of resources and time. Using a postal questionnaire would have afforded the opportunity to collate a large number of

responses with the potential to reach a variety of women who had used the maternity provision. Using a postal questionnaire would have allowed a wide variety of residential areas to be taken into consideration whilst the experience of the respondents could also be accounted for in the design of the questionnaire.

Yet acquiring a database of names and addresses of women who were going to use or were currently using the maternity provision would have been problematic. As this was the initial stage of the empirical research, contacts within the health care environment were new and fragile, with ethics committees conscious of user privacy. As such, the likelihood of a questionnaire being accepted by the ethics committees in a short period of time was improbable. A telephone questionnaire was also not an option as obtaining telephone numbers for women currently using the maternity provision would be problematic if not impossible.

Also, attempting to develop a questionnaire simply from the secondary data contained in the literature review appeared to be inadequate as current users and their views, expectations and perceptions had not be taken into account in the secondary data.

Furthermore, using a postal questionnaire could have exacerbated "non-response" problems (Gill & Johnson, 1991). A postal questionnaire would not only need to cater for literacy problems and the individual's ability to cope with the questions but would need to be interesting enough to the respondent so it would be completed and returned. Although a questionnaire which catered for all women would not be impossible, the quality and subsequent analysis of a postal questionnaire, which was basic enough for women of all educational backgrounds to understand and complete, was not considered adequate for the initial stage of this research. The opinions, expectations and perceptions of a broad sample were required for this foundation stage.

The research was to be conducted during October, November and December 1994 and was, therefore, carried out in the months preceding Christmas. It was considered optimistic to expect women to readily complete postal questionnaires during this time period. The other questionnaire option, that of a self administered questionnaire, was also considered improbable because of the season in which the questionnaires would be conducted.

Rather than collating quantitative data then, and to appropriately fulfil the objectives, the depth of participant responses could be sought using qualitative techniques. This would allow a smaller sample to be approached, with the opportunity to identify and expand on specific areas of interest. Using a qualitative approach would allow the researcher and the participants the time to consider expectations and perceptions in depth. The options available for collating qualitative data were ethnography, participant observation, interviews or focus groups.

Ethnography, the study of organisations or a particular social setting, allows the researcher to become immersed within the group in order to understand the meanings and significances that people put upon their own behaviour and that of others. Similarly, participant observation, which has its roots in ethnographic research studies, considers it appropriate for the researcher to adopt a role within an organisation. This is to understand the work situation at first hand and is used in the field of management services (Easterby-Smith, Thorpe & Lowe, 1991).

The idea of using an ethnographic approach to collect the exploratory data was considered, although the respondents were unlikely to work together, and their social setting was likely to be an antenatal or postnatal class. As women expecting their second or subsequent child would be less likely to attend these classes, this social setting would not provide a wide enough sample of novices and experts. As such, these approaches were rejected on the basis that they would not provide the depth of data required to fulfil the objectives.

Interviews would have provided confidentiality for the participants and, as some areas of treatment may be delicate in nature, the participants may have felt more comfortable in a one-to-one situation. Interviews would also allow the researcher to focus on one individual rather than a group of participants. As such a concentration of views would result which could specifically be attributed to one individual, their particular experience and their residential area.

However, interviews would not provide the breadth of issues which often arises as a result of interaction within a group. Generating discussion on aspects of health care would be more difficult in a one-to-one situation as the discussion would only centre on one experience. Although prompts could be used to expand on issues of interest, group discussions would have the advantage over interviews as the participants would prompt one another rather than the prompts being generated from the secondary data. As such, focus groups were chosen as an appropriate method for the first stage of empirical research.

3.3.3 Focus Groups

The initial stage of the empirical research was to be largely exploratory, establishing current views and opinions. Focus groups evolved as a natural choice, allowing a wider range of information, insight and ideas than responses secured privately (Malhotra, 1993). Focus groups can be used effectively as an exploratory tool in qualitative research (Easterby-Smith, Thorpe and Lowe, 1991) and could establish the level and extent of expectations in accordance with the objectives.

As the social backgrounds of women using the obstetric services is diverse in nature, it was important to ensure that the expectations, identified during the initial stage of the empirical research, were as broad as possible. Within the focus group discussion process, the perspectives of all members of the group are considered and attendees are not "add-ons" (Webb, 1992). As participants could be

considered extra or additional in a personal interview situation, focus groups again appeared most appropriate at this stage.

3.3.4 Design

Morgan (1988) established the main advantage of focus groups as the opportunity to observe a large amount of interaction on a topic over a limited period of time. As this was preliminary empirical research, it was appropriate to use focus groups in an effort to prepare for specific issues. Malhotra (1993) highlights variations of the standard procedure of focus groups, including Two Way focus groups, Dual Moderator groups and Duelling Moderator groups.

Two Way focus groups involves one target group listening and learning from a related group. This would limit the involvement of some participants, and as all the focus group members would be familiar with the topics being discussed, the necessity for one group to "learn" from another group was inappropriate. Further to this, as East's categorisations of novice and expert user were to be explored, the views of all participants were considered to be of equal importance.

Undoubtedly, there were to be occupational and residential differences because of the nature of the sample. A two way focus group could have included a mixture of participants from varying residential areas. However, to allow all views to be heard and to create an atmosphere in which these views could be exchanged comfortably, Morgan (1998) suggests a narrow sample size. Even group members who have similar backgrounds, incomes and occupations can demonstrate variability in both thoughts and beliefs. To establish any similarities and differences amongst sample groups, it was appropriate to conduct the groups without employing the two way method.

Establishing expectations and perceptions within the focus groups may have been assisted by a Dual Moderator group. Involving two specialists, one would be

responsible for the smooth running of the group and the other for ensuring all areas of questioning were covered. However, the groups were designed to be smaller rather than larger to stop the group fragmenting and pursuing their own conversations (Webb, 1992) and dual moderators may have inhibited the group by their presence.

The final focus group variation considered was the Duelling Moderator group. This method is designed to increase the group dynamics. Again there are two moderators, but each one would deliberately take opposing positions on issues to be discussed. As Walker (1984) highlights the importance of participants being able to speak their minds and respond to the ideas of others, moderators becoming involved may have over shadowed the perceptions and expectations of the group members.

Therefore, the most appropriate model for the focus groups used in the initial stage of the empirical research is the standard procedure model where a moderator, using a non-structured or semi-structured format, leads the discussion with a small group of respondents (Malhotra, 1993). The main purpose of this type of qualitative research method is to gain an insight from the target group on issues of interest to both the target group and the researcher. The unexpected findings from the free-flowing discussion often add the depth and value to this particular method.

3.3.4.1 Focus Group Formats

To aid the discussion on users' views, expectations and perceptions of the maternity provision, prompts were designed in the form of focus group formats by the author (See Appendices 2(a), 2(b) & 2(c)). These prompts were not designed to lead the discussion but to provide some similarity between the focus groups for the purpose of collation and analysis.

The focus group formats were designed using headings which arose from the secondary data. Rather than grounding the discussion in issues raised by the secondary data, the prompts contained in the focus group formats were only used if:

- the discussion went off on a tangent
- the participants appeared to be unable to generate their own discussion
- an issue had been discussed at great length and expectations and perceptions of other aspects of service provision was at risk of being overlooked

The prompts were very sparse and, although covered the three stages of the maternity process (namely the antenatal stage, labour and the postnatal period), the headings were simple and not designed to make women discuss issues they felt to be unimportant. For example, if the women were discussing antenatal appointments and had finished and were looking to the moderator to become involved, the headings used as prompts would allow the moderator to say "What about antenatal classes?" without underlining any issue as being more important than another.

The three likely alternatives to using the prompts were:

1. To use nothing and allow the discussion to spiral
2. To develop formats that were more specific and perhaps adapted from similar work
3. To provide the participants with the formats before they arrived

However, allowing the participants to spiral off on a tangent would make the collation, comparison and analysis between the focus groups problematic and would perhaps narrow the number of issues discussed. Also, if some groups were more dynamic or involved than others, they may generate more issues than those groups whose participants' were more introvert. Developing more specific formats

or replicating other studies was considered inappropriate as the opinions, expectations and perceptions were to come from the current users of the maternity provision. Finally, providing the participants with the formats before they arrived would only serve to introduce bias into the proceedings as the participants would be more likely to "prepare" answers.

3.3.5 Sampling

The sampling strategy used for this particular area of research was initially considered to be one of convenience. With the limitations of access, notwithstanding financial implications, convenience sampling would have been acceptable (Gill & Johnson, 1991). Webb (1992) also highlights that convenience sampling is often used in the exploratory stages of a research project; allowing the author a feel for the subject. However *quota sampling* more appropriately describes the sampling method used for the focus groups. Whilst targeting established gatherings, efforts were made to ensure the sample was more representative than simply one of convenience to ensure breadth of response and a variety of experience to test East's categorisations of novice and expert user.

Although non-probability sampling does not require the use of a sampling frame (Webb, 1992) and notably reduces cost, Aaker and Day (1990) highlight the disadvantages of this method. Advocating the use of probability sampling, they demonstrate difficulties in both bias and uncertainty. However, as this empirical research was only to be the first of three stages and was ultimately to be quantified by the use of a questionnaire, these authors consider the use of quota sampling appropriate as this research is exploratory in nature and initial positioning.

This non-probability sampling was developed by adapting the ACORN classification system. This system, A Classification of Residential Neighbourhoods (ACORN), categorises individuals on the basis of their residential grouping. For example, residents of affluent suburban areas or residents inhabiting poorest

council estates can be identified and categorised using this system. The types of residential areas chosen for the sample were:

- poorest council estates
- less well off council estates
- older houses of intermediate status
- modern family housing with higher incomes
- affluent suburban housing

These areas were chosen as they house a cross section of the users of the maternity provision. The quota for the focus group research was allocated with careful consideration to the available sample. Difficulty in obtaining the quota as a result of time limitations reduced the number of pilot groups. However, as the pilot groups were not very different from the focus groups in terms of content or style, the number of pilot groups was not considered problematic and the pilot group fulfilled its purpose as a test group.

3.3.6 Data Collection

The study was conducted in Edinburgh and the surrounding towns and villages. Initially, contacts previously made by the author, during the literature search and primary information gathering, were approached for guidance in identifying established groups who may wish to take part in the research. Using the telephone directory, potential associations were also contacted. It was possible to determine the residential area of the groups by the use of the postcode included in the directory. A phone call was then made to that particular group to assess the feasibility of holding a focus group at their venue and the likelihood of women to take part as participants.

Although there was an inherent bias in this method as the author was recruiting women who wanted to take part in the research, the women or the groups they belonged to were chosen on the basis of their residential area to provide a wide scope of perceptions and expectations. Time and resources were factors which excluded the possibility of bringing individuals together to form groups.

However, the greatest reason for not bringing individuals together to form groups was that as the women would be unknown to each other :

- It was difficult to predict if the women, being heterogeneous in nature, would communicate well
- The focus group format would have to have included ice-breaking material and as such, would have been more intrusive and more "leading" than the formats which were used. More detailed formats, as previously discussed may have introduced unnecessary bias into this initial stage of exploratory research

Organisations contacted and invited to take part in the research included the National Childbirth Trust, National Health Service Antenatal/Postnatal Classes, Postnatal Depression Society, Stepping Stones and Community Centres that organised events/classes/childcare for mothers. This allowed all ACORN groups, chosen for the study, to be covered. Explanations were given to all organisations as to why they were contacted and detail of the overall study was given. Obvious considerations were centred on the potential participants and whether they would wish to take part in the study. Having established a contact within the organisations, a follow up letter was sent to confirm arrangements and explain the format of the group discussion.

As outlined by Judith Bell (1992), obtaining trust was to be essential in negotiating access. In some cases, the author was required to be interviewed before being allowed to proceed with the study. Establishing what was to be expected from the participants became the key issue and generally the issues to be raised during the

focus groups were approved. Barriers or objections to the study were largely concerned with the intimacy or personal nature of the questions to be asked. Reassuring organisations that the potential participants would be required to focus on expectations, perceptions and referent groups often dispelled these concerns.

If organisations continued to appear uncomfortable, no further attempt was made to involve that particular group with the study. For example, an organiser of a postnatal depression group within the Edinburgh area demonstrated her discomfort with the research. She considered the study to be wholly inappropriate for their members but did provide contact names and numbers of other organisations who may be able to help.

A report of the salient findings of all the focus groups was to be made available to the organisations on completion of this first stage. Strict anonymity was promised for all individuals taking part. It was hoped this would be a motivating factor in organising the collection of data.

Suitable meetings were arranged in surroundings within which the participants would feel relaxed and in an environment where they would not be disturbed (Easterby-Smith, Thorpe and Lowe, 1991). This was to enable the participants to feel uninhibited and contribute freely to the discussions. In most cases the focus groups were conducted in the usual gathering place of the participants. On two occasions, however, focus groups were conducted in the home of the author.

On completion of every focus group, a letter of acknowledgement was sent to the organisation or group in question, to thank them for taking part and highlighting their importance within this research. In some cases this was invaluable as the second stage of the empirical research relied heavily on these contacts.

The size of the sample was determined with consideration for accurate information. This was to involve precision in assessing the widest spread of

information from the residential areas available. As access was a limiting factor for this initial stage of empirical research, the principle of setting minimum acceptable targets recommended by Patton (1980) was adopted. A sample of six groups was selected to give both contrasting experiences and expectations. The primary concern of the sampling strategy was to assess the participants' expectations, perceptions and referent groups. This strategy involved not only varying the participants by residential area but by including participants differentiated by experience: first time mothers, mothers with more than one child and single mothers.

The participants of the focus groups were previously known to one another. There was no cross matching or duelling of groups to ensure the participants were not alienated or inhibited by women who were perceived by the groups to be socially or culturally different. Novice and expert respondents were included in the same group, which may have biased the results. However, as the groups were designed to be small in size, each of the focus group members were allowed to contribute, in depth, about their individual experience. The **Table 3.2** describes the participants of the pilot focus group, with the remaining tables (**3.3 - 3.8**) concentrating on the subsequent samples for the remaining groups. The identity of the individual associations is not shown to ensure confidentiality.

3.3.6.1 The Pilot Group

The pilot group was conducted at Napier University (See **Table 3.2**) in a informal setting, with comfortable seats, refreshments and a well lit room. This was to encourage the participants to feel both welcomed and valued and to involve them in the discussion as much as possible. The group was carried out to:

- assess possible group dynamics
- establish the way in which novice and expert users contributed in a group environment

- identify issues which may be problematic in terms of being discussed at great length or not being discussed at all
- afford the moderator the opportunity to become more experienced and familiar with focus groups

The pilot group contained three novices (first time mothers) and three experts (women with two or more children). The six members of the group were eager to discuss issues which arose either as part of the focus group format or as topics raised by group members. All of the pre-test respondents had an affiliation with the university; either as a student or a staff member. Their commitment to the study was demonstrated through their enthusiasm and their willingness to discuss personal issues.

The participants were also from a variety of residential areas; including modern family housing, older intermediate housing and affluent suburban housing. Although the residential areas were varied, the category of higher ACORN grouping used to assist analysis and interpretation of the focus group findings (See **4.2**), included these residential areas. The subsequent use of this data, therefore, substantiates the analysis of the findings.

The purpose of the pilot group was to check the flow of the informal design, to curtail tangents which may develop and to establish the relevant data as determined by the focus group members. It fulfilled its purpose. The original intention was that more than one pilot focus group would be undertaken; perhaps two or three. However, in the event, further pilot studies were not conducted as the information obtained from the original pilot was extremely comprehensive. As previously identified (See **3.3.5**), as a limitation of access and in an effort to use quota sampling, further pilot groups could not be conducted.

3.3.7 Conducting the Focus Groups

Since it is commonly asserted that the quality of information obtained during a focus group is largely dependent upon the moderator (Walker, 1994; Easterby-Smith, Thorpe & Lowe, 1991; Webb, 1992) a large proportion of time was dedicated to the pre-planning of this study as the author was also the moderator.

The focus group format guides (See **Appendix 2(a), 2(b) & 2(c)**, which aided the discussion (See **3.3.4.1**) were designed and pre-tested with the aid of six focus group participants. These members were established contacts of the university and were representative of a range of child birth experience and of expectations.

The pre-test phase also provided the opportunity to explore the issue of tape-recording the focus groups and the extent to which doing so might interfere with the data collected. All the focus groups lasted between one and half hours to two hours. The information obtained from the pilot focus group was of such detail it was decided to include the transcripts from these interviews into the overall analysis. This was deemed possible, as the pre-test was very similar to the actual focus groups with very few amendments. The pre-test was conducted at the beginning of October just prior to the 6 focus groups detailed in **Tables 3.3-3.8**.

Focus Group A (See **Table 3.3**) contained 4 novices and 1 expert member, resident in modern family housing, and was the only group to be completely unbalanced with novice and expert participants. However, as the expert had seven children, the extent of her personal experience was considered to be significant. This group was conducted, in the afternoon (with some children present), at the home of the author and was largely made up from a recent postnatal group run at the local GP surgery on the outskirts of Edinburgh. The expert member was a friend of one of the novice participants who was informally asked, by the novice participant, to attend the group.

Focus Group B (See **Table 3.4**) contained 4 experts and two novice members, resident in older intermediate housing. This group was conducted in a local church hall, on the outskirts of Edinburgh, and was made up from parishioners of the church. The priest was approached for assistance which was readily given and the focus group was conducted in the evening (no children present) in an informal side room. The group was designed to have a mixture of experience and this group contained a woman who had delivered twins.

Focus Group C (See **Table 3.5**) contained 3 experts and 3 novice members, resident in affluent suburban housing. This group was conducted in the home of the author, on the outskirts of Edinburgh, and was made up from members of the National Childbirth Trust. The co-ordinator of the National Childbirth Trust was approached for assistance which was readily given and the focus group was conducted in the afternoon with the children of the participants present.

Focus Group D (See **Table 3.6**) contained 3 experts and two novice members, resident in the poorest council estates in Edinburgh itself. This group was conducted at the local centre for childcare (a centre specifically designed to give single and cohabiting and married parents a "break" from their children and offer the parents the opportunity to take part in other activities). The community worker was a contact of the supervisory team and assisted in the setting up of the focus group. The group was conducted in the morning without the children of the focus group participants.

Focus Group E (See **Table 3.7**) contained 3 experts and two novice members, resident in older intermediate housing. This group was conducted in Linlithgow (to the West of Edinburgh) and was arranged by the co-ordinator for childminding for that region. This group was designed to incorporate women using the maternity provision of St. John's Hospital in Livingston. One expert participant had six children with her experience spanning twenty years. The group was carried out in the afternoon with no children present.

Focus Group F (See **Table 3.8**) contained 4 experts and 2 novice members, resident in less well off council estates. This group was conducted in Edinburgh itself at the local meeting place of the participants. It is a centre specifically designed to give single and cohabiting and married parents a "break" from their children and offer the parents the opportunity to take part in other activities - similar to that of Focus Group D. The community worker running the organisation was suggested by an another organisation who felt they could not contribute to the research when approached by the author. The community worker was extremely helpful and the group was carried out in the afternoon with no children present.

Letters to those helping to co-ordinate the arrangements for the focus groups were mailed the same week as the pre-test took place. Telephone calls to confirm details were made two days before the focus groups were conducted. The participants, as detailed above, were either in their typical gathering establishment or in the home of the author. These discussions took place between October and December. All the discussions were tape-recorded and transcribed by the author as soon as possible after the focus group occurred. The analysis of the focus groups was completed by March 1995.

Respondent	ACORN Classification	Number of Children	Types of birth	Use of painkilling drugs
A	Older housing of intermediate status	1	Hospital birth, normal delivery	Gas and air Diamorphine
B	Older housing of intermediate status	1	Hospital birth, normal delivery	Gas and air Diamorphine
C	Modern family housing with higher incomes	1	Hospital birth, forceps for delivery	Epidural
D	Older housing of intermediate status	2	Hospital birth Caesarean both children	Epidural both occasions
E	Modern family housing with higher incomes	2	Hospital birth both children, forceps delivery first child	Gas and air for first birth TENS machine for second birth
F	Affluent suburban housing	2	Hospital birth first child, home birth second child (independent midwife)	TENS machine first birth Unaided second birth

Table 3.2: Participants of the Pilot Focus Group

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
A: *Modern family housing and higher incomes*	**A1**	7	All hospital births Second birth caesarean
	A2	1	Pregnant with second child Hospital birth; normal delivery
	A3	1	Hospital birth; normal delivery
	A4	1	Hospital birth; forceps delivery
	A5	1	Hospital birth; emergency caesarean section

Table 3.3: Profile of Focus Group "A" Participants

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
B: *Older housing of intermediate status*	**B1**	3	All hospital births First birth: breech/caesarean Second birth twins: one forceps
	B2	2	Both hospital births Normal deliveries
	B3	2	Both hospital births Normal deliveries
	B4	1	Hospital birth Normal delivery
	B5	1	Hospital birth Normal delivery
	B6	3	All hospital births Normal deliveries

Table 3.4: Profile of Focus Group "B" Participants

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
C: *Affluent suburban housing*	**C1**	2	Both hospital births First birth; forceps delivery
	C2	2	Both hospital births Normal deliveries
	C3	1	Hospital birth; emergency caesarean
	C4	1	Hospital birth; normal delivery Expecting second child
	C5	2	Both hospital births Normal deliveries
	C6	1	Hospital birth; forceps

Table 3.5: Profile of Focus Group "C" Participants

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
D: *Poorest council estates*	**D1**	1	Hospital birth; normal delivery
	D2	1	Hospital birth; normal delivery
	D3	2	Both hospital births; normal deliveries
	D4	3	All hospital births; First child spent time in the Special Baby Care Unit
	D5	4	All hospital births; normal deliveries

Table 3.6: Profile of Focus Group "D" Participants

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
E: *Older housing of intermediate status*	**E1**	1	Hospital birth; emergency section
	E2	6	Children's ages ranging from 1 to 20 All hospital births All normal deliveries
	E3	3	All hospital births First child; forceps delivery
	E4	2	Both hospital births First child; emergency section Second child; elective section
	E5	1	Hospital birth Normal delivery

Table 3.7: Profile of Focus Group "E" Participants

Focus Group & ACORN class	Label	Number children	Characteristics of Birth
F: *Less well off council estates*	**F1**	2	Both hospital births Normal deliveries
	F2	1	Normal delivery
	F3	2	Both hospital births Different hospitals Normal deliveries
	F4	1	Hospital birth; normal delivery Pregnant with second child
	F5	2	Both hospital births; normal deliveries
	F6	2	Both hospital births; normal deliveries

Table 3.8: Profile of Focus Group "F" Participants

3.3.8 DATA ANALYSIS

The data collected from the focus groups was analysed using the Ritchie and Spencer (1994) *Framework* analysis method. This method depended on the manual coding, charting and mapping of the data. *Framework* comprises of five stages which are outlined below:

1. *Familiarisation*: An overview of the range and diversity of material which has been gathered and sets firmly, in context, the material as a whole. Essentially, this stage allows the researcher to become immersed in the data, whilst listing key themes and recurrent ideas.

2. *Identifying a Thematic Framework*: During this stage, the key issues, concepts and themes were identified and the framework model (See Diagram **3.1**) was developed by drawing upon a priori issues, emergent issues as highlighted by members of the focus groups and analytical themes emerging from recurrence of particular experiences.

3. *Indexing*: Having developed the thematic framework, the data collated from the focus groups was systematically indexed.

4. *Charting*: As the range of attitudes and experience for each issue was crucial to the overall theme of this research, charting was particularly important. It involved compiling charts for each subject area with headings and sub-headings drawn from the index. The cases were ordered according to the sample sub-groups and kept in the same order for each subject chart. Systematic ordering allowed for comparison between the themes and issues as dictated by the respondents. The transcripts were also referenced to allow each source to be detected.

5. *Mapping and Interpretation*: At this stage, the key characteristics were drawn together to interpret the overall data. The information was used to find associations between the salient issues and was governed solely by the original research questions to be addressed. The associations are mapped within the confines of the data and alternative explanations were sought and were uniformly appraised against the actual data.

"The argument is that research and analysis in qualitative data is about "feel" and an implicit component of all research is the honesty of the person conducting the research." (Easterby-Smith, Thorpe & Lowe, 1991)

With this in mind, then, *Framework*, was particularly expedient as the raw data is available in a comprehensive format. If the field of qualitative research badly needs explicit, systematic methods for drawing conclusions, (Miles & Huberman, 1984), then the strength of *Framework* is that it gives this process clarity. It provides a trace to the original data which other forms of qualitative analysis do not readily allow (See for example: Patton, 1980).

In addition, there has been insufficient direction in the majority of information concerning processes and procedures associated with data analysis (Bryman & Burgess, 1994). Although conceptualisation is widely recognised, there is often inadequate indication of how to develop data from coding to conceptualisation. *Framework*, however, has the advantage of making the whole process of analysis visible.

As this strategy allows both the charting and mapping of the analysis, confidence in this method is apparent because of the visible nature of the conceptualisation. As the procedures for this particular analysis are repetitive, the reliability of the interpretation is enhanced because of its rigour and systematic nature. It also

prevents the researcher being caught between succumbing to confusion or choosing some simple, plausible but false explanation.

Rather than forcing data within logico-deductively derived assumptions and categories (Jones, 1987) *Framework* is driven by the original data. A full review, as opposed to a selective reflection, of the material is possible. Clearly, as all themes were to be explored *Framework* was superior to other methods of analysis which may not cover all dimensions. *Framework* allowed all relevant incidents to be made available. Another advantage of this method was the ease, moreover the flexibility, with which categories can be added as the analysis progresses (See Appendix 1). As the coding index was not required to be completed initially, it could be adapted fairly readily.

Finally then, *Framework* was not only logical and systematic but practical. As always, the limitation of time was prevalent; particularly as this primary research was only one of three stages requiring analysis.

Summary

In summary, the focus groups set out to explore the attitudes, expectations and perceptions of women who had experienced the obstetric services before, during and after birth. Gordon and Langmaid (1988) state qualitative research is used optimally for situations which will:

(1) Increase understanding

(2) Clarify real issues, and possibly most importantly

(3) Explore consumer motivations and attitudes

McCracken (1988) insists qualitative data should be exact and economical, allowing only for the minimum amount of assumptions to be made. These considerations have influenced the design of the focus group study discussed in

this chapter and forms the foundation for the analysis and presentation of results detailed in Chapter four.

3.4 IN-DEPTH INTERVIEW METHODOLOGY

3.4.1 Necessity for Research

The previous section explored the design and methodology of the first stage of empirical research. The second stage of primary research was to further establish the expectations and perceptions of women, using the obstetric services, by researching their views both before and after the birth of their children.

The findings of the focus groups provided current expectations, attitudes and perceptions of participating focus group members. Current issues concerning the participants using the obstetric services, since the implementation of *Working for Patients* (1991), were established. However, the focus group members communicated that their expectations during the postnatal period were undoubtedly affected by their experience. As indicated in the previous section, the measuring of expectations remains a difficult task as, invariably, expectations change over time (Parasuraman, Berry & Zeithaml, 1991) and are affected by internal and external influences. The initial function of the second stage of research, therefore, was to substantiate or question the findings of the focus groups, using "before" and "after" measures.

3.4.2 Data Collection Methods

The research methods available to measure the expectations and perceptions of women using the maternity provision, before and after the birth of their children were identified as additional focus groups, postal, telephone or self administered questionnaires or in-depth interviews.

Additional focus groups, incorporating both antenatal and postnatal groups, were considered as an option. This would allow further evaluation, using a familiar model. The number of women sampled would be larger than that of in-depth interviews as focus groups containing six to eight women could be conducted in a two hour period. Interviews would only afford the opportunity to question one person in the same time frame. Focus groups would also provide greater scope for depth of questioning in comparison to questionnaires.

However, although the members of the focus groups used in this study appeared to be uninhibited by:

(a) The personal nature of the topic

(b) Issues raised during the discussions

(c) and the probing of individual experiences

the confidentially of a one-to-one interview could simply not be employed. Considering the necessity of overall insight, the longitudinal issues or the specific questioning of the findings from the initial exploratory empirical research could not be achieved through the use of focus groups.

An alternative choice, at this stage, would have been quantitative research. A questionnaire could, potentially, have fulfilled the objectives of the second stage of empirical research. A large number of women currently using and recently discharged from the services of the maternity provision could be approached for their expectations and perceptions of their obstetrics' experience. After consideration, however, using questionnaires would have involved several barriers to data collation.

The research participant would have to be questioned both before and after giving birth. For the purpose of the research, the *same* individual would have to be questioned, before and after giving birth, to measure the fulfilment or disconfirmation of expectations.

Considering the options of a postal, telephone and or a self administered questionnaire, a postal questionnaire would have been most appropriate as it would be affordable, less time-consuming and possibly most acceptable to the women participating as they could complete the questionnaires at their leisure. A telephone survey may have caused irritation as the participants may be trying to rest during pregnancy or establish a routine during the postnatal period. Building a large enough database of telephone numbers of women who would participate was anticipated as potentially difficult considering the barriers to access experienced whilst conducting the focus groups (See **3.3.6**).

A self administered questionnaire, although not impossible, would involve visiting the women on two occasions, probably at hospital or at their home, before and after the birth. As a large volume of women would be needed to participate for a quantitative sample, this method was discounted as the research was only to be conducted by author.

A postal questionnaire, therefore, was the only likely quantitative method to be used for this second stage of empirical research. A postal questionnaire would have to be distributed in two parts. That is, a questionnaire would have to be sent before the birth and after the birth. To receive a "completed" questionnaire would mean a participant would have to return two questionnaires.

If both parts of the questionnaire were not returned, the data would be incomplete and difficult to analyse as a result. This was the first barrier to data collation. Also expecting women to complete two questionnaires may exacerbate the likelihood of

a poor response rate. The return of postal questionnaires is generally poor (Webb, 1992).

The second barrier that rendered questionnaires an impracticable alternative was that the data collated from the focus groups would have to be used to develop the questionnaire. This would have suggested the results from this exploratory research were conclusive (Malhotra, 1993). Evidently by developing the questionnaire from the information collated during the exploratory stage, the questionnaire could only produce confirmation of the focus group data. This research method would not allow the depth of information provided by an in-depth interview which could substantiate or question the focus group findings. As the data from the initial stage remained exploratory, if it was used to design a questionnaire, the questionnaire analysis would be inconclusive.

3.4.3 In-depth interviews

The purpose of this second stage of empirical research was to supplement previous findings whilst allowing accurate and inclusive personal accounts to extend the boundaries of the existing aims and objectives. As in-depth interviews could be designed to be highly focused, ensuring interviewee time was carefully utilised and interviewer effects were minimised by the use of specific questions (Patton, 1980), in-depth interviews were chosen as a research method for this second stage of research.

The common characteristic of this interview approach focuses on the interviewee responding in their own words to express their own personal perspectives. As patient care is individual and heterogeneous in nature, the in-depth interview approach was an appropriate method. Although the interviews had a structured-direct approach as discussed by Webb (1992), the questions were designed in such a way that a questionnaire format was not used. Indeed, the questions were designed to be open-ended to allow free expression.

The standardised open-ended interview approach was chosen for this stage of the research and provided a semi-structured format. This type of interview structure was chosen from the options of semi-structured or unstructured interviews.

The unstructured interview was considered as an option because the format would have allowed an exploration of the focus group findings. This non-directive interview would have been used to ascertain information on issues which had not been raised during the focus groups. However, Easterby-Smith, Thorpe and Lowe (1991) advise against the researcher believing an unstructured interview is the most appropriate method of producing a clear picture of the interviewee. In essence, if the interview appears to have no purpose, the interview data may incorporate bias as the interviewer becomes unsure of the "questions" being answered by the interviewee.

The interviews were to provide "before" and "after" expectations and perceptions of a service experience. If unstructured interviews were incorporated into this stage of empirical research, the longitudinal comparison would become extremely difficult, if not impossible. Considering the potential difficulties of both the inherent bias and the analysis of the unstructured interviews, semi-structured interviews emerged as the most appropriate method of defining concepts which arose from the focus group analysis.

Semi-structured interviews also provided the "before" and "after" comparison required to substantiate:

(a) Women's expectations before the birth; including women with varying parity

(b) Whether the experience of childbirth changed the initial antenatal expectations and the depth of change

(c) Women's use of referent groups and the degree to which the women felt their referent groups to be informative

The three main advantages of using the in-depth interview for this stage were as follows:

(1) The in-depth interview would allow the researcher to spend a greater length of time with each participant to build rapport and trust

(2) Using the in-depth interview before and after the birth was likely to guarantee a response whereas a postal questionnaire was likely to produce a poor response rate

(3) The in-depth interview was considered to provide greater qualification of key ideas and re-current issues raised during the focus groups, as greater probing of participants would be afforded to the researcher during the time available.

3.4.4 Design

Easterby-Smith, Thorpe & Lowe (1991) describe interviews as the basis for understanding the constructs that the interviewee uses to develop her opinions and beliefs.

Considering this, the interview objectives were designed to provide the foundation for understanding the constructs of the interviewee (Burgess, 1982). Specifically, the in-depth interviews were developed to ascertain the following:

(1) An understanding of the constructs which shape women's expectations and opinions of the obstetric services

(2) The range and dimensions of the effect of experience, using the variable of parity

The in-depth interviews were designed to establish if the expectations of women using the obstetric services changed over a period of time. The antenatal interview format allowed data to be collated from the interviewees on their current perceptions of the maternity services and how these perceptions may have been influenced. The postnatal interviews were designed to reflect the depth of change in perception of the interviewees, considering both experience and referent groups.

The interviewer had a set format of questions to ask the interviewees during both the antenatal and postnatal interviews (See Appendix 3(a) & 3(b)). The questions were similar during both interviews to maintain the "before" and "after" evaluation which would substantiate or question the initial findings.

When designing the in-depth interviews, there was a distinct advantage of using this method over other primary research methods. The main reason for this was that the interviews would allow a number of basic questions to be worded precisely in a predetermined fashion, while permitting the interviewer more flexibility and probing. This was achieved by integrating an interview guide approach with a standardised open-ended approach (Patton, 1980).

Techniques to gain rapport with the interviewee were also employed, as being interviewed for research was not expected to be a common experience for the chosen sample (Kinnear & Taylor, 1991). These techniques included similarity in dress, accent and demeanour between the respondent and interviewer.

The antenatal interviewees were unlikely, for example, to be wearing tight fitting suits and the postnatal interviewees would wear clothing which was both comfortable and machine washable. This dress code was adopted by the interviewer. Similarly, the interviewer, whilst designing the questions, omitted

unfamiliar words or expressions which could be misunderstood by the interviewees. If the interviewees sat more comfortably on the floor, the interviewer followed suit. Maintaining these general rules allowed the initial contact to remain relaxed.

The interviews were conducted in the home of the interviewee. This automatically allowed the interviewee to retain control over the proceedings and produced a relaxed atmosphere during the interviews.

Kinnear & Taylor (1991) demonstrate the difficulties with bias in recording responses. To keep any bias to a minimum the antenatal and postnatal interviews were taped. A record then existed which not only reproduced the intonation of the interviewees but that of the interviewer. Therefore, the data was retained in a form which could be used as a measure of bias regarding questioning, intonation and language.

Patton (1980) highlights an advantage of the standardised open-ended interview as the focusing of the interview; so the time of the interviewee is carefully utilised. As this second stage required the interviewees to be interviewed, both during the antenatal and postnatal period, their participation throughout the entire process was vital. Using focused questions demonstrated that the interviewees time was important, although enough time for depth of questioning was allowed.

An additional technique to establish the value of the participant was derived from Easterby-Smith, Thorpe & Lowe (1991). As suggested, the maintenance of the interviewee's co-operation could be aided by the interest and commitment shown by the interviewer, and this was incorporated into the design of the interview. If, for example, the interviewee were to mention the name of their husband or partner in the antenatal interview, this name was noted and used in the postnatal interview.

The topic areas to be raised during the interviews arose from the analysis of the focus groups. The format of the interviews incorporated different probing methods (See Appendix 3 (c)). For example, if the women described their labour care as "excellent" they were asked to provide an incident that demonstrated their perception of excellence. They were also encouraged to describe any difficulties incurred during labour.

Similarly, the format was used to identify the use of referent groups throughout the process. The informal referent groups, such as family, friends and peer groups were often described by the interviewees as being most helpful. Therefore, explanatory probes (Easterby-Smith, Thorpe and Lowe, 1991) were used to ascertain the depth of the information given to the women by these groups and how influential this information became during the process.

3.4.5 Sample

One of the disadvantages of using in-depth interviews as qualitative research is the ability to work only with small samples. This may limit the ability to generalise about complete populations. However, the peer pressure generally observed in focus groups was absent during the interviews. Webb (1992) suggests the use of in-depth interviews, without the bias of peer pressure, will produce more valid results. This compensated somewhat for the limited sampling.

As the main objective of the in-depth interviews was to substantiate or question the findings of the focus groups, the interviewees, reflected the sample identified for the focus groups (See **3.3.5**). Douglas (1976) identifies qualitative research as an investigative process and as such suggests developing information by contrasting, comparing, replicating, cataloguing and classifying the object of the research. To compare the information produced through the initial exploratory study, quota sampling was also used during the in-depth interviews. Ritchie and

Spencer's *Framework* (1994) provided the structure for both cataloguing and classifying the interview data.

The quota sampling of the interview participants reflected the ACORN classification system (See **3.3.5**). The interviewees were carefully chosen in relation to their parity and residential area, the latter of which was easy to identify through use of their postal code. The postcode of the participants was identified through the contacts available which included the personnel department at Napier University, hospital records and occasionally the interviewees themselves. The participants are identified in the Sample Profiles of Interviewees. (**See Tables 3.9, 3.10 & 3.11**).

Interviewee No.	Acorn Classification	Parity	Characteristics of Birth	Type of Hospital
Pre-test 1	Less well-off council estates	0+(1)	First child, forceps delivery	Middle-sized maternity unit Scale 2*
Pre-test 2	Affluent suburban housing	1+ (1)	First birth resulted in emergency caesarean section; second birth elective section	Small cottage hospital Scale 1*

*** The scales are indicated in Table 3.12**

Table 3.9 Profile of Pre-Test Interviewees

Interviewee No.	ACORN Classification	Parity	Characteristics of birth	Type of Hospital
A1	Older housing	0+(1)	Hospital birth, epidural	Scale 3
A2	Older housing	0+(1)	Hospital birth, gas and air	Scale 3
A3	Modern family housing	0+(1)	Hospital birth, diamorphine	Scale 2
A4	Less well off council estate	0+(1)	Hospital birth, forceps	Scale 2
A5	Poorest council estate	0+(1)	Hospital birth diamorphine	Scale 3

Table 3.10: Sample Profiles of Novice* Interviewees
(*Novice being women pregnant and delivering their first child)

Interviewee No.	ACORN Classification	Parity	Characteristics of birth	Type of Hospital
PP1	Affluent suburban housing	1+(1)	First birth hospital, second birth home. No pain relief	Scale 3
PP2	Older housing	1+(1)	Two hospital births; epidural first birth, gas and air for second	Scale 3
PP3	Less well off council estate	1+(1)	Two hospital births; more than five years delay between the children	Scale 3
PP4	Poorest council estate	2+(1)	Three hospital births; epidural first birth, gas and air the last two	Scale 2
PP5	Modern family housing	1+(1)	First birth in a large teaching hospital, second in cottage hospital. Gas and air for both	Scale 3 & 1

Table 3.11: Sample Profiles of Expert* Interviewees

(*Expert being women pregnant and delivering their second or subsequent child)

The interviewees both from Napier University and the participants selected through associates of focus group members, disclosed their postcode (if they wished to continue) during the initial contact. The primary contact with potential interviewees was, in these instances, a telephone call. The postcodes for the potential interviewees recruited at the maternity hospital was obtained through the hospital data system. Only the women appropriate for the quota sample were approached and invited for interview. The respondents were typically interviewed three months before the birth and within three months after the birth.

This sample was to specifically include women residing in modern family housing, inhabitants of older housing of intermediate status and occupants of affluent suburban housing, in addition to samples from the less well off and poorest council estates. This non-probability sampling reflected accurately the samples already established through the focus groups.

The most important variable for sampling, other than residential area, was the parity of the interviewee. A balance amongst the participants was sought in relation to the number of children they had. This was to allow the continued exploration of East's categorisations of novice and expert (See **3.2.3**). The sampling ensured all the first time mothers were not all living in affluent suburban housing, nor were the mothers with one or subsequent children only sampled from those resident in less well off or poorest council estates.

The sampling also ensured that the interviewees did not all attend the same hospital. This was to give a broader set of responses to key service issues. To demonstrate the differences between the hospitals attended by the interviewees, Table **3.12** highlights the facilities available in the hospitals used in this sample. For ease of application, the hospitals have been awarded a hospital category. These categories only reflect the facilities available in the hospitals used in this sample and was developed by the author only to demonstrate the *differences* between *facilities*.

Maternity Unit Facilities	Category 1 Availability	Category 2 Availability	Category 3 Availability
Ability to perform caesarean sections	Not available	Available	Available
Provision of SBCU	Not available	Not available	Available
Shared care with GP	Not available	Not available	Available
Water birth	Not available	Not available	Available
Overnight nursery provision	Not available	Not available	Available

Table 3.12 Maternity Unit Facilities by Category

3.4.5.1 Pilot Study

Two pilot interviews were conducted before commencing the widespread study. The pre-existing questions set the discussion between the interviewer and the two volunteers who raised questions regarding the phrasing of the existing questions. The volunteers were also given the opportunity to raise any issues they felt were important and had been excluded from the interview format (See Appendix 3(a) & 3(b)).

The pilot interviewees were both suggested by focus group members, highlighting the importance of maintaining regular encounters with established contacts. Both the volunteers had been absent from the initial focus group study and their input during the pilot stage was regarded as innovative and topical. As the interview approach was built on this pilot study, it would be reasonable to suggest the ideas for tone and intonation were grounded in the data collected in these pilot interviews.

The pilot interviewees represented groups of differing parity and resided in varying social and economic areas. The first pre-test interviewee was pregnant with her first child and the second interviewee represented the category of women with one child or subsequent children. Both respondents had individual experiences but could identify with the questions and the process of the obstetric services from antenatal to postnatal care.

Further pilot interviews were not conducted at this stage as the information received during the pilot interviews was extremely comprehensive. As a result, it was strongly felt further pilot interviews would be of little additional benefit to the design. Moreover, as the in-depth interviews were to be conducted both during the antenatal and postnatal stage, the time involved in recruiting interviewees for this purpose became time consuming. Therefore, the interviewees recruited were used for the interviews rather than the pre-test interviews.

3.4.5.2 Obtaining the Quota

The aim of the interviews was not only to explore the analysis of the focus groups but to place emphasis on the broadest scope of responses. The sample which was considered most appropriate involved as many individuals, from as many varying residential areas as possible. Access to individuals associated with members of the focus groups provided the foundation for the initial interviews, but was unable to produce a large enough sample and alternative methods were sought.

Easterby-Smith, Thorpe & Lowe (1991) advise contacting the personnel department within the parent organisation of the researcher for research participants. This opportunistic approach is supported by work conducted by Webb (1992). The personnel department of Napier University provided names of women working in the institution who were going on maternity leave. These women had a variety of occupations, ranging from cleaner to senior lecturer. Women from this sample were approached and some were recruited.

The recruiting approach for this particular sample of women involved using the internal telephone system at Napier University, to initially contact the women going on maternity leave. An explanation of the author's research position within Napier University, followed by a brief explanation of the research, introduced the women to the overall subject. At this stage in the recruitment, the women were offered the opportunity not to become involved or to be sent additional information on the research and their potential role within it as suggested by Judith Bell (1993).

The majority of these women requested additional information which reinforced the information already given on the telephone and was followed up by a telephone call within one week of distribution (Taylor & Bogdan, 1984).

Although the response rate from the Napier University employees was high, the sample did not reflect the broad scope considered appropriate for this research. Therefore, the Midwifery Manager at one of Edinburgh's maternity hospitals was approached and, with the approval of the ethics committee, allowed the author access to women arriving for antenatal appointments. Two separate days were spent in the antenatal waiting lounge to recruit the appropriate sample of participants. The recruitment process was similar to the one adopted for Napier employees, although the initial contact was face-to-face rather than over the telephone. The sample was identified by the use of hospital information on parity and residential postcodes.

The difficulty in recruiting women for the interviews did not stem from access difficulties but from recruiting an appropriate sample of women with varying parity (parity being the number of children a woman has had). Women with more than one child were especially difficult to recruit. They often commented that they had little time to be involved in research as a result of looking after their children. Identified recruitment techniques (Aaker & Day, 1990), such as explaining the

value of their responses, were employed to encourage this group of participants to become involved in this stage of the research.

3.4.6 Data Collection

The sample of interviewees were to be interviewed in their home. Judith Bell (1993) indicates the importance of facilitating venues for interviewees. As the participants would either be pregnant or coping with a relatively new infant, arranging the interviews either at the university of the author or at a neutral venue appeared inappropriate in the circumstances. Most importantly, the women would feel comfortable in their own home, with facilities for both themselves and their children in the surrounding environment. Indeed, as the infants often did not have an established a routine, the nature of postnatal interviews occasionally involved sporadic questioning.

3.4.7 Conducting the Interviews

Both the focus group format and the in-depth interview format followed the progression of the maternity process: antenatal care, the labour period and the postnatal stay in hospital. The respondents were taken through each stage of the Maternity process separately. At each stage (antenatal, labour and postnatal experiences) the interviewees were directed to a specific time period in their experience and were encouraged to discuss this alone.

All the interviewees were comfortable with the topic area and lengthy explanations of the obstetric provision were not necessary. The interviews lasted between one hour and one and half hours with the length of the interviews allowing enough time to explore the women's past behaviour and experience. Current attitudes and future intentions were also established in an effort to reflect how past experience influenced future behaviour.

As with the previous stage of qualitative research, the interviews were all tape recorded to preserve the purely verbal part of the interview (Gummesson, 1991) and capture the intonation of both the interviewer and interviewee. Body language or non-verbal communication between the interviewer and informant was recorded separately, although no adverse behaviour was apparent. The tape recording during the interviews were far less obvious than the recording of the focus groups as the recording equipment was smaller. As the interviews were occurring on a personal, one-to-one basis, a far smaller, less obtrusive instrument could be used to record the interview. A dictaphone as opposed to a large tape recorder was used and, as such, the equipment employed was barely noticeable.

The interviewer explained the use of the recording would aid the analysis and that the interviewee should request the removal of the equipment at any stage if they felt uncomfortable. The resulting behaviour was positive as the interviewees demonstrated no physical signs of discomfort and none of the participants requested the removal of the equipment.

This qualitative data, in tape form, aided the indexing stage of the *Framework* analysis. In particular, the ability to extrapolate precise meaning from the language used, aided the analysis of this second stage extensively.

3.4.8 Data Analysis

The data collected from these interviews were analysed using the Ritchie and Spencer (1994) *Framework* analysis method. This method, utilised for the analysis of the focus groups, depends on manual coding, charting and mapping of the data. *Framework* and its advantages as a qualitative analysis method have been extensively discussed (See **3.3.6**).

Summary

In summary, this second stage of empirical research set out to substantiate, question, moderate or reject the findings and analysis of the initial exploratory focus groups. The interviews were designed and conducted to establish women's expectations and perceptions of the obstetric services throughout the maternity process. The design allowed both:

- the observation of depth of change in attitude and behaviour as a result of experience
- the evaluation of the influence of referent groups and their importance throughout the women's experience

The results of this second stage were to provide the foundation for the quantitative survey conducted to complete the triangulation of data and produce statistics to support the generalisability of the overall analysis.

3.5 QUESTIONNAIRE METHODOLOGY

3.5.1 Necessity for Research

Chapter five illustrates the analysis of the in-depth interviews, highlighting the expectations and perceptions of the sample utilising the obstetrics service. The findings of this work identified significant differences between novice and expert users (See **3.2.3**) and demonstrated continuity of expectations and perceptions amongst respondents occupying specific residential areas. This final piece of empirical research, described in the following chapters, provides quantitative analysis, substantiating both the previous studies of focus groups and in-depth interviews and providing triangulation of data.

The analysis of the in-depth interviews provided a study of interviewees both before and after the birth of their child. The interviewees demonstrated both physical and emotional changes over the period in which the interviews were conducted, with the novice interviewees demonstrating significant changes in both expectations and perception. The purpose of the in-depth interviews, which was to substantiate, question or moderate the findings of the exploratory focus groups, successfully produced findings supplementing the analysis of the first stage of the empirical research. Thus validity and reliability were added to the initial findings.

The questionnaires were designed to establish the breadth and scope of the previous empirical findings by using four major hypotheses (See **Table 6.2**), substantiating the analysis of the overall study. Specifically, the questionnaires were to provide:

(1) Generalisation on human and social behaviour of the sample (Easterby Smith, Thorpe & Lowe, 1993) specifically focusing on parity and residential area

(2) Data to substantiate previous analysis and to identify areas of non-application to deepen the understanding of East's (1992) categorisations

As Parasuraman (1986) defines attitudes as "[an] underlying mental state capable of influencing a person's choice of actions and maintaining consistency across those actions", with the elements of this thesis dependent on these variables, the objectives and methodology were designed to incorporate both expectations and the respondent's perceptions of choice.

3.5.2 Data Collection Methods

As methodological triangulation of data was considered appropriate for the research design (Morgan & Smircich, 1980; Easterby Smith, Thorpe & Lowe,

1993), varying types of quantitative methods of data collection, including postal and telephone surveys, were considered for this final stage of empirical research. The collation and analysis of the quantitative data is particularly significant as it may provide evidence to suggest that, by using a large sample of respondents, previous empirical research conducted in this study are not congruent (Fielding and Fielding, 1986). Simply, this final stage of empirical research could substantiate the previous findings or discredit part or all of the initial research.

Clearly, the final stage of this empirical research was to clarify, on a broad scale, the expectations and perceptions of women using the obstetrics service. These responses were then tested using four major hypotheses (See **Table 6.2**). Questionnaires evolved as the natural choice to substantiate the analysis of stages one and two and to generalise on the findings of the third stage of analysis.

Triangulation of data, as a methodological approach to the overall design of the empirical research was considered, explored and employed. Convergent validity [For example see: Easterby Smith, Thorpe & Lowe, 1993] confirms the validity of data by comparing the instrument with other independent measurement procedures. The empirical stages of research were independent as, although they were sequential, they were conducted with different participants at various time periods. As validity would be provided for the data analysis, this added weight to the argument for using both a triangulation approach, and utilising questionnaires in the research design.

Three main types of communication between the questioner and the respondent were considered; telephone interview, postal questionnaire and one-to-one interview.

The communication choices were fundamentally influenced as a result of the following:

- A balanced response rate from participants occupying various residential classifications was necessary to substantiate previous findings and analysis

- The initial empirical research demonstrated that particular sections of previous samples did not complete birth plans or hospital questionnaires and were therefore unlikely to complete independent questionnaires

- Access to patient addresses or telephone numbers demands time-consuming administrative work and would have required permission from the patient *before* mailing a questionnaire for completion

- Patients would have to complete the questionnaire with few incentives

With the limitations of these factors, the following methods of research were considered for the final stage of empirical research.

3.5.2.1 Telephone Interview

The telephone interview, as a method of gaining questionnaire responses, was considered for a number of reasons; not least the convenience (Webb, 1992). The telephone interview would allow the researcher to telephone from a central location, reducing travelling costs and time. Additionally, the response rate would be greater than postal questionnaires, yielding between sixty and eighty percent (Malhotra, 1993). Bias and interviewer error would also be minimised using this method and a wide geographical spread could be reached. With this particular study, women with children could be contacted at a time convenient to them, coinciding with the routine of their infant.

However, the sampling of the telephone respondents initially caused concern. The difficulties in gaining access to patients have previously been explored (See **3.3.2**) and it was access to patient's telephone numbers which would have made this piece of research extremely difficult. The midwives in the maternity hospitals in Edinburgh voiced concern regarding patient confidentiality and privacy. One particular hospital, used for this study, expressed specific concern regarding telephone surveys and postal questionnaires as the patients would be contacted without their previous knowledge.

Using a telephone survey to contact the patients, without their previous consent, may have alarmed the individuals concerned and hospital security may also have been questioned. Obtaining telephone numbers for the sample would have been problematic. The option remained to call households randomly. However this was wholly inappropriate as:

(a) It could take quite some time to actually locate a household in which a woman was expecting a child or had a new-born infant

(b) The response rate would be poor as new mothers particularly, would become suspicious of both the questions and motives of the data collection

(c) Gaining a balance between varying residential areas and parity (number of children a woman has had) would be impossible

These factors compounded the limitations on this particular method and therefore a telephone survey was discounted as a method of obtaining questionnaire responses.

3.5.2.2 Postal Questionnaire

The postal questionnaire was considered as a serious alternative to the telephone survey. Advantages of using this particular method (Webb, 1992) included the anonymity of the questionnaire and affording the respondent confidence to complete the questionnaire without embarrassment. Additionally, the respondents would have the time to complete the questionnaire. The women in this study could lay aside the questionnaire until a break in their routine occurred, for example, completing it when their infant was having a nap.

Highly developed literature is available to aid the design of a postal questionnaire (Lockhart & Russo, 1994; Paxson, 1992). However, the response rate for postal questionnaires is typically less than 15% (Malhotra, 1993) and estimates cite ten weeks delay between administering the questionnaire and retrieving the initial responses (Lockhart & Russo, 1994). An additional problem was that one hospital, used extensively in this research, would not agree to postal questionnaires being distributed without prior agreement from the patients. The additional time and resources involved in recruiting an appropriate sample before the questionnaires were sent out, with no guarantee of questionnaires responses, rendered a postal questionnaire as unworkable.

3.5.2.3 One to One Interviews

Responses to the questionnaires were necessary to substantiate previous findings, as anterior empirical research included significant respondent differences, in both parity and social experience. The sample of respondents for the questionnaire, therefore, required not only a balance with novice and expert mothers (See **3.2.3**) but the scope of respondents residing in previously identified residential areas (See **3.3.5**).

Using additional focus groups would have been an easier option to collate responses at this stage, but would not have provided the large sample size required for quantitative research to triangulate the data. Difficulty in recruiting women to participate in the research was compounded with the potential respondents either tired at the end of their pregnancy or caring for a new infant.

The information collated during this final stage of research should also have incorporated a longitudinal design as detailed and employed for the interview methodology (See **3.4.4**). This would have enabled the "before" expectations and the "after" perceptions of the questionnaire respondents to be measured separately.

Although, recruiting respondents to be interviewed, in the hospital or at home after the birth of the child, would not have been impossible, the number of respondents necessary for a quantitative sample would have made this option impractical as only the author was conducting the research. Although this would have been the preferred choice of the author, the time and resources involved in such a project was beyond the reach of this thesis.

A compromise had to be sought. With a large volume of respondents necessary and with this sample of respondents occupying a variety of residential areas, postnatal maternity wards arose as an obvious choice to isolate women able to conform to this criterion.

This option was not without limitations, the most significant being that expectations of the antenatal period and the labour period would be considered after the experience had taken place. The expectations and satisfaction of the initial postnatal period would be current as the questionnaire would be administered during the initial postnatal time frame. The implications of choosing this approach for this particular study meant, that although the appropriate sample would be

reached, the expectations would not be considered before the experience had taken place.

As such, the recommendation for further research to quantitatively measure expectations would further ensure the data was accurate, reflective and valid. Although the questionnaire findings have been informally discussed with local midwives, who find the data to be concurrent with their experience, antenatal expectations from a quantitative sample would be appropriate for future research.

3.5.3 The Direct Approach

The author self administering the questionnaire, on a personal interview basis, would allow a structured and direct approach for both interviewer and interviewee. Postcodes could be used to ascertain the residential area occupied by the respondent. Webb (1992) discusses several advantages of this specific method, adding credence to the use of this approach for the third stage of this empirical research.

To complete this study, a balance of data was required from respondents residing in a variety of residential areas. The personal interview affords the opportunity to the interviewer of maintaining a balance of respondents by the utilisation of postal codes. If refusal rates are particularly extensive for one particular residential grouping, the scope exists, in the width of respondents available, to maintain a balance of responses.

Previous stages of empirical research have demonstrated less well off and poorest council estate residents are reluctant to complete either birth plans or hospital questionnaires. However, respondents residing in less well off and poorest council estates, provided invaluable data for this exploratory and developing research during both the focus groups and the in-depth interviews. The assumption that, respondents residing in less well off and poorest council estates are comfortable

and possibly more familiar with personal contact, was drawn from this information.

Utilising the personal interview for questionnaire responses is notably time consuming and expensive in comparison to similar research methods (Malhotra, 1993). However, as the limitations of a postal questionnaire have previously been discussed, with this method unlikely to exact an acceptable response rate, individual interviews were comparable in both time consumption and expense. As the interviewees would be well represented within the postnatal maternity wards, both cost and time resources would be substantially reduced.

Finally, as the respondents would be expected to complete the questionnaires with no tangible incentives, it was considered an advantage to conduct a personal interview for questionnaire completion. The personal interview would afford the researcher the opportunity to personally demonstrate gratitude for the contribution to research made by the respondent.

3.5.4 Questionnaire Design

The focus in this section is upon the actual design of the questionnaire and a full copy of this survey is included (See Appendix 4).

Gill & Johnson (1991) describe four inter-related issues on questionnaire design which include: the overall presentation of the questionnaire, the form of response, the questionnaire focus and the phraseology. These issues provided the grounding for both the format and design of the questionnaire.

Overall Presentation

As the questionnaire was self administered, the necessity for overall presentation of the questionnaire to be aesthetically pleasing was reduced. The most important element in the overall presentation of the questionnaire was the ease with which it could be completed by the interviewer.

Form of Response

The questionnaire was to be administered to the women during their postnatal stay in hospital and, as a result, was likely to be completed at a bedside. Employing the use of a clipboard would facilitate ease of completion. Additionally, the questionnaire pages were only printed on one side of the A4 paper to limit confusion and speed up the overall process. Questions only applicable to expert respondents were in italics to visually separate them from questions applicable to all respondents.

Questionnaire Focus

The focus of this questionnaire was specifically to centre on the testing of the four major hypotheses (See **Table 6.2**). This was to allow the salient issues raised during the initial stages of empirical research, namely *the effect of parity*, *service provision experience*, *referent groups* and *residential area* of the respondent to be further considered. This was to substantiate or discount findings from the focus groups or in-depth interviews which considered the adaptation and use of East's categorisations of novice and expert to the maternity provision.

As a result, the contribution and implications for knowledge from the questionnaire data was to be:

- The difference in expectations and perceptions of the maternity provision by novice and expert users and, as a result of these differences, its potential importance for service provision

- The difference in expectations and perceptions of the maternity provision by respondents from a variety of residential areas and, as a result, its potential importance for service provision

As the objectives for this stage of the empirical research were particularly incisive, questions which did not clearly serve the purpose of the study were identified at an early stage and disregarded.

Phraseology

Phraseology of the questions utilised in this research was extensively evaluated through the pilot study. As the characteristics of the population from which the sample was to be drawn demonstrated variance and diversity in both residential classification and experience, the questionnaire design avoided use of jargon, esoteric terminology and inappropriate ambiguity.

Although the phraseology could have been explained through the one-to-one interview, during the completion of the questionnaire, the bias or imposing assumptions drawn from the explanations may have led to inaccurate data collation (Webb, 1992). As a result, the pilot study encouraged respondents to highlight ambiguous phrases or words which may cause confusion and these were removed or replaced. During completion of the questionnaire then, no additional explanations were required.

As the questionnaires were completed after the experience had taken place, questions that referred to antenatal expectations were written in such a way to highlight that expectations prior to the experience were sought. Although the wording could not remove the inherent bias of exacting expectations after the event, it aided the respondent and the researcher to assess a variety of time periods during the postnatal stage.

3.5.5 Sample

Approximately, sixty six thousand children are born every year in Scotland. The sample reflected about a tenth of the births in Scotland *over a one week period.* A sample of 170 women, stratified by parity and residential classification, was drawn from the two major maternity units in Edinburgh. As these maternity units account for the majority of women giving birth in the Lothian area, it was deemed appropriate to source the sample from these hospitals.

A third maternity unit, largely covering the west area of Edinburgh, declined to take part in the study as a result of their contribution to the Lothian Maternity Survey (1992). This survey has been utilised in the literature review and focus group members attending this third maternity unit voiced their opinions during the first empirical stage of this research. The women using this third maternity unit, therefore, have had some input into the research. However, the results of the overall study will reflect the service provided by the two hospitals involved in this third empirical research stage.

During the initial conception of this research, it was hoped it would be possible to conduct a UK based questionnaire, the responses of which would allow generalisations to be drawn on a nation-wide scale. The ability to do so was limited by one major factor: access.

Access and obtaining permission from Ethics Committees in both Wiltshire and Hampshire to conduct the questionnaire using the same questionnaire and method as used in Edinburgh was met with difficulties. A separate questionnaire could have been developed and administered, and a change in approaching the patient to complete a questionnaire would have possible. However, the comparative value at this point would have been lost and as such the findings are based in the Lothian region of Edinburgh.

A potential difficulty for a national study, although of less importance, are the slightly different government policies for the Scottish Maternity Provision and that of England and Wales. This may have proved to be problematic during a comparative study. Even though the comparative study did not take place, these differences in policy have been discussed during the literature review.

In sum, it is not possible to draw generalisations from this sample for the Obstetric Services at large. Instead the results can claim to be representative of users of the Lothian Maternity Services and the users expectations of such services.

3.5.6 Data Collection

Within the confines of the objectives outlined at the outset of this chapter, the questionnaire design was guided primarily as a result of the conceptual framework which was, in turn, aided through the literature review. A small focus group was subsequently conducted with a selection of women to assist in the development and pre-testing of the questionnaire.

3.5.6.1 Pilot Study

Focus group members were encouraged to discuss questions which they felt may be sensitive, confusing or lengthy (Oppenheim, 1984). With the inclusion of a member who was only in the antenatal stage of her care (novice), the expectations

element of the questionnaire was fully scrutinised. This also added weight to the credibility of the questionnaire results as expectations were focused on at the outset of the questionnaire development.

Group members' help was also sought in generating criticism of both layout and presentation, with particular emphasis on wording.

The focus group members comprised a small semblance of women utilising the maternity services. As the questionnaire was to be administered through the local maternity units, a useful addition to the pre-test focus group was a nursing professional. This woman, a mother of two, not only represented a formal link with the NHS, but contributed to the overall design as a "professional". The profile of the focus group members is given in Table **3.13**. Each of the respondents had affiliations with organisations previously utilised in stages one and two of this empirical research.

ACORN classification	Label	Number children	Characteristics of Birth
Modern family housing	PQ1	4	All hospital births First birth: breech/caesarean Second birth twins: one forceps Third birth normal delivery
Less well off council estate.	PQ2	1	Normal delivery
Older, intermediate housing	PQ3	2	Hospital births, normal deliveries
Older, intermediate housing	PQ4	0 (1)	Waiting to deliver

Table 3.13: Profile of Focus Group Members Pre-Testing Questionnaire

3.5.7 Conducting the Questionnaire

Initially, the questionnaire principally employed closed questions, whilst the remainder of the survey measures the respondents' opinions and attitudes. The introductory questions were 'closed' to facilitate not only the ease of data collection but to allow the respondents to readily understand the nature of the questions. The ease of completion was intended to produce a comfortable atmosphere. A degree of discrimination was introduced, in the latter half of the survey, through the use of six point Likert scales and through ranking questions. With these questions, the interviewee was able to verify the importance of particular prevalent topics.

Bagozzi (1994) indicates the strength of closed, Likert and ranked questions as both ease and speed of completion. This was vital as the questionnaires were being completed in a postnatal maternity ward. Activity levels were high, in addition to the requirements of the new infant. The obvious concern with these questions was that the requirement of depth of response may not be achieved. However the response category 'other' was included to allow a degree of free response.

3.5.8 Data Analysis

The subsequent analysis for the questionnaire was provided by SPSS, a statistics package for social scientists. As descriptive statistics were required, several packages were explored. SPSS was both relatively uncomplicated and able to indicate correlation, patterns and trends. Additionally, SPSS was selected on the grounds that both the menu and manual were user friendly. However, any of the available packages could have coped with both the collation and analysis.

The questionnaire presentation and layout was completed on SPSS. Tabulation of data and its expression in percentages was the first stage of the analysis. This provided an indication of the frequency of events, say the number of women who had attended antenatal classes. Whenever possible, Norusis (1993), suggests cross tabulations of related variables should be obtained to identify anomalies.

Typically, of greatest interest to researchers is the significance of their results. That is, the hypothesis that two variables of a cross tabulation are independent of one another. The Pearson Chi-Squared is generally used to test this hypothesis and is calculated by summing over all cells the squared residuals divided by the expected frequencies. The calculated chi-squared is then used to compare with the critical points of the theoretical chi-squared distribution. After this calculation has occurred, an estimate is then produced of how likely, or unlikely, the variables are to be independent.

Summary

The aim of the research design was to contribute to the development of understanding the nature of users' expectations of the maternity provision in Edinburgh. Within these confines, the focus groups and in-depth interviews provide depth, whilst the survey contributed breadth.

The advantage of the focus groups and in-depth interviews was that they provided an understanding of the nature of users and the characteristics which influence their expectations. The disadvantages of these methods, however, were the time and resources required and difficulties associated with analysing and interpreting qualitative data.

The quantitative survey sought to provide specific information regarding maternity issues. This method was chosen as the end study to substantiate and validate the

findings of the qualitative research as similarities amongst data collated through these three methods would enhance the reliability of the research.

The following chapters consider the analysis of the empirical research, the design of which has been discussed in the context of this methodology chapter.

CHAPTER FOUR

4.0 FOCUS GROUPS

4.1 Introduction

Chapter three discussed the methodology used for the empirical research, giving a detailed examination of the way in which the investigation was conducted. The results and analysis of the focus groups are provided in this chapter. The analysis focuses on the issues which arose during the first stage of the primary research and utilises *Framework*, devised by Ritchie and Spencer (1994), which is also detailed in chapter three.

The results in this chapter broadly fall into two sections. The first deals with expectations, attitudes and beliefs held in common by all participants in the focus groups, highlighting the similarities of process and experience. Secondly, significant differences in opinion between the focus groups participants exist on a number of issues, for example, antenatal class attendance, pain relief during labour and postnatal length of stay in hospital. These issues will be considered separately.

As advised by Ritchie and Spencer (1994), the format for the focus groups was to ascertain the key themes and recurrent ideas apparent throughout the collated data. Fourteen themes presented themselves, falling neatly into three categories: antenatal care, labour and postnatal care which are manifest in Table **4.1**. The themes became the axis on which the index flourished, warranting easier mapping and analysis.

ANTENATAL THEMES	LABOUR THEMES	POSTNATAL THEMES
• **Patterns of Choice** -choice of hospital -alternative types of birth -motivation to comply -use of referent group -use of experience • **Antenatal Preparation** -information -developing expectations -completing birth plan -use of antenatal classes • **Attitudes to Antenatal Classes** -preconceptions -attitudes of staff -measures of attendance -length of classes -involvement of partners • **Antenatal Staff** -Shared care -Continuity of care -Relationships between patients & staff -Advice/information • **Appointments** -Length of appointments -Expected waiting times -Partners involvement • **Preparation by Patient** -Previous experience -Use of information -Involvement of patient -Involvement of partner	• **Physical Affects** -Transportation -Initial contact -Pain as expected -Normative beliefs -Availability of staff • **Information** -Information on pain relief -Previous experience -Expectation of intervention -Information on intervention -Medical staff as experts • **Mental Affects** -Loss of dignity -Previous experience -Patient/staff relationship -Use of students -Use of family members -Use of partners -Birth plan	• **Postnatal support** -Breast feeding -Availability of support -Patient/staff relationship -Information • **Employees** -Attitudes to one another -Use of questionnaires -Mother as patient -Experience affecting support -Use of nursery -Doctors v Nurses • **Routines** -Expectations -Length of stay -Visiting Hours -Safety & Security • **Facilities** -Cleanliness -Food -Availability of facilities -Motivation to comply -Ward Sizes -Temperature -Ease of use to SCBU Special Care Baby Unit

Table 4.1: Overview of Consistent Key Themes

Building on information gathered from the literature review, the guides for the focus groups (See Appendices 2(a), 2(b) & 2(c)), centred upon expectations and experiences of women using the maternity provision. These guides were developed by the author and included topics a woman would encounter when using the maternity provision. For example, as these expectations and experiences were recorded for three specific areas of the maternity process; namely the antenatal stage, labour and the initial postnatal period, information regarding pregnancy was an issue raised for the antenatal stage discussion.

This section concentrates on the results of the focus groups, considers the indicators discussed in the introduction and initially contemplates similarities during the antenatal period of the participants.

4.2 Focus Group Design And Methodology

The author had a number of points to cover during each focus group. The format was to ensure all terrain was covered and enabled the author to guide the group whenever the discussion appeared to be irrelevant to the research area (Lowe and Neilsson, 1989). Control was exercised over the direction of the focus groups using a series of prompts (See Appendices 2(a), 2(b) & 2(c)).

As the groups were exploratory, it was necessary to guide their thoughts and ideas as many women had the inclination to spiral off on a tangent (Webb, 1992). The members of the focus groups affiliated to the National Childbirth Trust, for example, had a tendency to discuss breast feeding. Although this is extremely important and often reflects the use of differing referent groups, it was important that this was not the sole issue to be discussed. Obviously there was considerable scope within the focus groups to be flexible, as most of the focus groups lasted two hours, reducing the necessity to be too constrained.

Since the women, although enormously diverse in character, had to a certain extent, received similar antenatal and postnatal care, lengthy explanations of the childbirth process were not necessary. It was a topic area all the women were

both comfortable and familiar with. The length of the focus groups allowed enough time to incorporate discussion on the women's past experience and behaviour, current attitudes and future intentions. Initially the format was non-directive in approach, progressing to phrasing that became more specific.

General Issues Common To All Focus Group Participants

4.3 ANTENATAL ISSUES

A reflection of the logical progression of the maternity process appeared to be an appropriate way to conduct the focus group discussions. As such, antenatal issues were intially raised and included choice of hospital, use of referent groups, aspects of health care, expectations of hospital food, appointments and waiting times. These are explored in the following section.

4.3.1 Choice of Hospital

The similarities amongst all focus group participants arose throughout the course of the discussion. Although 42 participants took part in this first stage of empirical research, 38 appeared not to have made a conscious decision to go to one particular hospital to give birth. Indeed, the overlying impression was that the participants rarely exercised their ability to choose between hospitals, relying on the discernment of the GP. Typically, the women expected the GP to decide the hospital for the birth, with the participants indicating it was usually the nearest hospital to their home.

The focus of this research reflects the existing use of the obstetric services. Currently, the total number of home confinements is 0.6% of total deliveries [in Scotland] and in England, 1% of the total (The Scottish Office, 1994). As a result, the data reflects this trend and largely concentrates on women who had hospital births. However, the sample did not exclude women who had home confinements.

4.3.2 Use of Referent Groups

Similarities were such that all participants, without exception, utilised the experience of either friends or relatives who already had experience of childbirth. The use of referent groups for experts, namely the focus group members who had two or more children, was far less obvious than the need for referent groups of participants with only one child.

For example a focus group participant when pregnant with her first child, residing in a poor council area, commented that when she found out she was pregnant she knew what to expect as:
"I've got two sisters who've both had bairns (children)"

Focus group participants having delivered two or more children were more likely to share experiences:
"I would tend to ask other mothers first... [for any little queries]*...that had maybe gone through the same thing. Reassurance that* [the situation] *it's normal."* (Participant, Focus Group C)

4.3.3 Tangible & Intangible Aspects of Health Care

The expectations, as communicated by the focus group participants, were identified as either tangible or intangible. Elements of health care treatment can be labelled as both tangible and intangible, for example, tangible aspects of the role of doctors and nurses can be identified as output and recovery rates. Conversely, some service aspects of the role of doctors and nurses are characteristic of intangibility (See **2.4.3**) and include empathy, sensitivity and the role of assurance. As the perception of a service is highly subjective, the tangible aspects are easier to assess. However, if the service is being evaluated as an overall experience, both tangible and intangible aspects will inevitably be considered by the individual assessing the service encounter.

Throughout the focus groups, the topics raised by the participants concentrated solely on the intangible aspects of service quality (Berry, Zeithaml & Parasuraman, 1990) as outlined in Chapter Two. Focus group members refused to be drawn on technical areas of treatment, for example, if the participants had a forceps delivery, their perception of the necessity for forceps delivery was difficult, and often impossible, to ascertain. This can be associated with the respect and reverence the participants appeared to hold for the medical profession:

" I put myself in the hands of the medics. I just said carry on".

(Participant, Focus Group E)

The term credence which has previously been explored (See **2.4.8.4**) outlines the possibility that some aspects of treatment cannot be assessed by patients as they feel they are not qualified to do so. Therefore they have no alternative but to trust the medical profession unreservedly. Discussion on and around technical aspects of treatment with the focus group members, then, appeared not only to be inappropriate but unproductive.

4.3.4 Expectations of Hospital Food

The women's perception of service was, on the whole, diverse. However, the subject of food gauged similar responses from the majority of participants. Although the women did not react positively when hospital food surfaced as an area for discussion, 40 of the 42 focus group members dismissed food as a low priority. Notably expectations of food were poor:

"No I hadn't expected it to be good [the food] - *it was food and I ate it"*

(Participant, Focus Group A)

"I never thought about it [the food] *beforehand. I don't really think anyone sees past the labour"*

(Participant, Focus Group A)

"I thought it would be unappetising and it was"
(Participant, Focus Group B)

4.3.5 Antenatal Hospital Appointments

GP and hospital appointments were raised as an issue during the focus groups. Often this topic was discussed mostly by the expert participants (mothers with two or more children) and concerned child care problems.

"It's the kids you have you worry about"
(Participant, Focus Group C)

"Waiting yourself is OK - it's when you've got the other bairns wi' you"
(Participant, Focus Group D)

However, all focus group participants considered antenatal appointments disappointing as inadequate time was allowed for each appointment, either at the surgery or the hospital.

"You were literally out in seconds"
(Participant, Focus Group C)

"They (medical professionals) can only cope with you for two minutes at a time"
(Participant, Focus Group B)

Novices (first time mothers) particularly, expected the appointments would afford them an opportunity not only to discuss their medical situation but seek reassurance about their emotions. However, the majority of women felt "hurried" or "rushed", especially within the realms of the hospital environment.

"I didn't think the doctors were very helpful. It says on yer card, if you have any questions don't hesitate to ask your doctor or midwife and they're pushing you out the door and you're trying to think of things to ask them"
(Participant, Focus Group F)

4.3.6 Waiting Times

Perhaps compounding the disappointment of the focus group members was the length of time many participants waited to consult with the professionals. Although the majority of the women considered the GP surgery to be efficient with its schedule, hospital waiting times were considered lengthy with little reward when the examination was conducted. Upon arriving for hospital appointments, the women expected to wait, both through personal experience and from information gained through referent groups.

"When I went to Simpsons you could be waiting all morning - then they'd take all three of you at once"
(Participant, Focus Group B)

The focus group participants were discontented when discussing this issue. The participants were guided from this topic if, and when, the atmosphere became negative. The natural progression for the focus groups, within the discussion, provided scope for the transition between antenatal preparation to the labour period. The recurrent antenatal themes are manifest in Table **4.2 (i)**.

Antenatal Recurrent Themes	The Affect of Experience
GP taking responsibility for choice of hospital	*Novices and Experts allowed their GPs to choose their hospital for them*
Use of referent groups	*Novices to a greater extent utilised referent groups*
Ability to prioritise	*Novices and Experts prioritised health of baby over all other issues*
Concern about waiting times	*Experts raised this issue as they had to wait with their other babies or toddlers*
Concern about length of appointments	*Novices felt "rushed" and sought reassurance*

Table 4.2 (i) Antenatal Similarities Amongst All Focus Group Participants

Labour Recurrent Themes	The Affect of Experience
Medical staff considered to be "experts" in their professional areas	*Novices and Experts raised this theme, agreeing unreservedly*
Midwives cited as having continuity of experience	*Novices and Experts raised this theme, agreeing unreservedly*

Table 4.2 (ii) Similarities Throughout Labour: All Focus Group Participants

Postnatal Recurrent Themes	The Affect of Experience
Poor availability of nurses	*Novices highlighted this to a **greater** extent*
Poor availability of information	*Novices highlighted this to a **greater** extent*
Concern regarding use of nursery	*Novices highlighted this to a **greater** extent*
Concern regarding security	*Novices and Experts both expressed concern*

Table 4.2 (iii) Postnatal Similarities Amongst All Focus Group Participants

4.4 LABOUR ISSUES

The next topic introduced for discussion was the labour period. The following section explores the labours' of focus group participants, their perceptions of the medical professionals and the role (s) of their partner.

4.4.1 Labour

The pilot focus group prepared the author for the discussion regarding the labour period. As the participants were enthusiastic whilst discussing their labour, this particular topic required gentle guidance to ascertain expectations of what the women thought would happen, as an alternative to anecdotal stories, which merely described what did happen. However, the subject of labour enhanced the atmosphere of the focus groups, elevating the spirits of the group members. Positive aspects of their treatment and gratitude at the safe arrival of their infant were acknowledged at this juncture.

4.4.2 Medical Professionals as "experts"

With only one exception, the participants indicated their confidence in the hospital medical staff, specifically using repetition of the term "experts". The women confided they "had put themselves in the hands of the doctors and nurses" citing the experience of the medical profession.

"You're going in to the experts aren't you? You know they're there for that reason"

(Participant, Focus Group A)

"Once they said it was best that the babies were induced because they were small, then I felt I should go along with that because should anything have occurred - and I had disagreed with them - I didn't want that responsibility."
(Participant, Focus Group C)

Their expectation of the professionals culminated in a healthy baby and a healthy mother, although the latter was of less importance to the participants.

"There were obviously things I didn't like and although I had hopes and wishes of what the birth would be like - in the end you're grateful for a healthy baby"
(Participant, Pilot Group)

The recurrent labour themes, which arose during the focus group discussions, are presented in Table **4.2(ii)**.

The focus group participants unanimously communicated their preference for the midwives over the doctors. This was regardless of the professional's gender. The preference for midwives arose as the participants considered midwives to have continuity of experience.

"Midwives are more up on it, I think."
(Participant, Focus Group B)

"Aye, ma midwife was brilliant but she was a right older yin and gave me advice about eating and stuff"
(Participant, Focus Group D)

"Oor midwife had a big family hersel, she had nine, so she had mare experience"
(Participant, Focus Group D)

This confirms the extensive research conducted by Bluff and Holloway (1994).

4.4.3 Role of the Partner

Participants recorded their pain and anxieties were often relieved by the involvement of their partner. There was, however, concern amongst eight of the women regarding the treatment of their partners during labour. Thirty two of the participants expected their partners to become fully involved in all aspects of their care. Although many women recalled how the professionals invited their partners to become as involved as possible, eight men were recorded as feeling isolated and ornamental. This phenomenon was not specifically related to residential area and appeared to be unaffected by social or cultural classification.

4.5 POSTNATAL ISSUES

Finally, postnatal experiences and perceptions were discussed. These focused on the postnatal stay in hospital and spanned issues such as support, information, nursery provision, repeat custom and security.

4.5.1 Postnatal Support

Finally the topic of postnatal support became the focus of the groups. Many of the participants expressed feelings of gratitude towards the nurses, principally, for their dedication and commitment. However, all focus group members voiced their concern with regard to the poor availability of nurses generally. The postnatal support provided at this stage appeared to be sporadic, not through insensitivity, but through inadequate resources.

"I went along to the nursery [with the baby] *and I said "Look, my baby's cold. They said "We'll be with you in a minute". An hour later I'm still sitting there.*
(Participant, Focus Group D)

"I must admit the girl who took me up to the ward was a bit abrupt. She gave me a row for getting up off the bed to go to the toilet. I mean I could have collapsed or anything - but I didn't know that. The only thing I knew was that I needed to go to the toilet and there was no-one there to take me."
(Participant, Focus Group A)

"I'm sure I had a midwife all the time [during labour] *but then it wasn't as busy."*
(Participant, Focus Group C)

"There weren't enough members of staff just to come round and ask you how you were getting on with breast feeding and things like that."
(Participant, Focus Group A)

This demonstrates the perishability and heterogeneity of the maternity provision (See **2.4.4** and **2.4.5**) and the variety of experience as a result of the time period in which the service was used.

4.5.2 Postnatal Ward Information

The length of time nurses spent with the women may have contributed to the next topic under review: postnatal information.

"The first time I changed Rebecca, I did it on the bed because nobody had told me the baby had to stay in the cot."
(Participant, Focus Group E)

"Paul's face used to go bright red when he did the toilet. I used to think there was something wrong with him. Nobody tells you these things."
(Participant, Focus Group F)

"The only problem was the first day I was in a panic as no-one said this is how to dress your baby or this is how to bath your baby. I had to ask the other women who were there and I eventually asked one of the midwives to show me."
(Participant, Pilot Group)

Focus group participants described the information they received concerning facilities, nappies and linen, upon arriving on the postnatal ward, as inadequate.

"There is one toilet at one end and one at the other and I don't know where you were to go to get the nappies."
(Participant, Focus Group B)

Furthermore, novices expected to be shown how to bathe and care for their children but, in many cases, poor availability of nurses required novices to observe experts on the ward to initiate their learning curve.

4.5.3 Hospital Nursery Provision

The focus group members noted feeling "guilty" if they requested their baby be allocated accommodation in the hospital nursery. Although the participants acknowledged the nurses lacked resources, many highlighted their own fatigue.

"He [the baby] was at the nursery for the first two nights. They gave him to me on the third night but I didn't want him because I was up all night with him. I felt really guilty because I felt I should be wanting him at night."
(Participant, Focus Group B)

Novices especially did not expect to feel exhausted after the birth of their infant, albeit their referent groups had discussed this with them at length. This may have compounded the feelings of group members who suggested, although the baby had priority of treatment and care, it should not have excluded the emotional and physical strain felt by the mother.

I found in 51[hospital ward number], *their priority was the baby. We came second.*
(Participant, Focus Group D)

I know this sounds selfish but I'm a smoker and I need a cigarette. Ye see babies getting stolen from hospitals if you just leave them. So I asked the nursery and they said "No, just leave him by the bed" and I thought that was terrible. I needed a fag.
(Participant, Focus Group D)

4.5.4 Repeat Custom

Experts (mothers with two or more children) expressed an increase in confidence on their second and subsequent visits to hospital.

"Mind you, if the baby was crying and the food was there [in hospital], *the food came first. The rest of the Mums all leave their dinner. I suppose I was like that with the first."*
(Participant, Focus Group B)

Green, Coupland & Kitzinger (1990) substantiate these findings, recording "parity was not particularly relevant to antenatal attitudes, although it was an important determinant of what happened to women in the hospital". These focus group participants indicated they had adequate support as they developed the assertiveness to request nursery facilities. Notably experts added that they considered the atmosphere within the hospitals to be significantly relaxed in comparison to previous visits, citing routine as flexible and far less rigorous.

"The routine [at the hospital] *has changed compared to five years ago. Now they say "whenever you are ready" or "whenever you've had your shower". Before it was a fight for the baths and showers at 6am."*
(Participant, Focus Group A)

4.5.5 Security

Perceiving the nursery facilities to be inadequate, the focus group members raised the additional concern of security. As the focus group participants were acutely aware of recent difficulties other hospitals had experienced with security, denying the participants the opportunity to leave the children in secure accommodation, whilst they showered or bathed, appeared unreasonable to all the women.

"I wanted to go for a shower and I took her along to the nursery and was told "You can't leave her here"".
(Participant, Focus Group B)

"I took him along to the nursery when I wanted to go for a shower and the nurse said "Huh! Don't be ridiculous. Leave him on the ward and one of the other mothers will look after him...The girl next to me was a mental health patient who had been released back into the community...I said you move me or her - because I didn't feel safe."
(Participant, Focus Group B)

Their positive expectations of security were not confirmed during their postnatal stay. Perhaps heightened media insight increased general security awareness. However, women who had used the service before the increase in media attention confirmed security concerns had always been an issue. Postnatal recurrent themes, and the effect of experience on the participants' perceptions, is manifest in Table **4.2 (iii)**.

Summary

The issues which arose as a result of the focus group discussions began with the choice of hospital. The majority of participants expected their GPs would decide in which hospital they would give birth. The focus group members participants then discussed their experiences with tangible and intangible examples and

provided their expectations and perceptions of their labour period. Finally, the availability of the nursery and nurses during the postnatal stay in hospital, caused concern amongst all participants. These antenatal, labour and postnatal perceptions were common amongst all focus group participants.

The following sections detail the differences in expectations and perceptions amongst the focus group participants. These differences appear to be as a result of social differences and the experience of the participant. A discussion on these differences and the exploration of the issues raised are based on these characteristics.

Issues Producing A Variance Amongst Focus Group Members

4.6 ANTENATAL ISSUES

The significant diversities between expectations, perceptions and experience of participant are considered in this section. The sample of focus group participants were selected from a variety of residential areas and included women from the poorest council estates and those resident in affluent suburban areas. The cultural and social differences between the focus group members heightened the distinctive perceptions of the individuals sampled. That is, there appeared to be issues that focus group participants from specific residential areas were more likely to agree on or were more likely to feel important to the overall service experience.

The types of residential areas chosen for the sample are as follows:

- poorest council estates
- less well off council estates
- older houses of intermediate status
- modern family housing with higher incomes
- affluent suburban housing

As described above, these residential areas were chosen using a selection of ACORN (A Classification of Residential Neighbourhoods) as proposed by CACI.

Higher ACORN Residents Residential Grouping: • *Affluent Suburban* • *Modern Family* • *Older Intermediate*	***Antenatal Stage*** • Novices attended antenatal classes with experts having attended classes previously • Novices completed birth plans with experts having completed these documents previously • Participants extensively used literature • Participants utilised **formal** referent groups	***Labour Period*** • Participants experienced no transportation problems • Knowledge of pain relieving drugs • Experts used TENS machine • Novices and experts used partner during labour	***Postnatal Stage*** • Longer length of stay in hospital • Elements of cleanliness and hygiene unacceptable • Participants disliked "open" visiting hours for peripheral family and friends
Lower ACORN Residents Residential Grouping: • *Less well off council estates* • *Poorest Council estates*	***Antenatal Stage*** • Novices and experts did not attend antenatal classes • Novices and experts did not complete birth plans • Infrequent, if any, use of literature • Participants utilised **informal** referent groups	***Labour Period*** • Participants experienced transportation difficulties • Poor knowledge of pain relief • Inability to discuss expectations of the labour period • Use of mother/sister/friend during labour	***Postnatal Stage*** • Shorter length of stay in hospital • Cleanliness and hygiene acceptable • Participants disliked limitations placed on visiting hours

Table 4.3: Summary of Differences Between Focus Group Participants From Varying Residential Groupings

The analysis of these issues, identified in the research model (See Figure **3.1**), continues with the format of antenatal experiences, labour and postnatal experiences. This logical progression allows the comparison between the earlier similarities, drawing upon the fluency of the participants experiences.

In essence, the differences between the focus group participants, rests on two key elements: attendance of antenatal classes and the information utilised by individual participants. The full scope of these differences is presented in Table **4.3**.

4.6.1 Developing Expectations

The foundation for antenatal expectations appears to be grounded in the first stages of pregnancy, and significantly experts resident in higher ACORN areas had more clearly defined expectations than novices living in the same residential areas.

"I think I'm super sensitive to light and smell - especially during labour...I really wanted the first baby at home [but was delivered in hospital]. But the second time round I could control everything...I had a dim room, a log fire blazing. I had all the people 'round me that I wanted 'round me. I could control it all - it was just wonderful. The second birth was everything I expected and much more."
(Expert Participant, Pilot Group)

Novices intensify their expectations during the antenatal stage, yet may have previously developed expectations out with the pregnancy stage through the use of referent groups.

"A lot of my friends have babies so I really asked them [for information] *quite a lot. But I think in the end it was my Mum* [who helped develop expectations of the labour period]. *Rebecca was an emergency caesarean. My Mum had had caesareans so I was prepared for it in as much that we'd spoken about it."*
(Novice Participant, Focus Group E)

Respondents resident in lower ACORN areas were more likely to develop expectations by considering the experiences of their family or friends or by watching television.

"When ma sister had a [caesarean] section...it was an hour before they found her blood group. When I visited her she was chalk white - she was really ill. Then when they did take her [for a caesarean section] - it was written in her notes - but they still had to phone my Mum to find out she was allergic to penicillin."
(Participant, Focus Group F)

"A was watching a programme about them going into different countries and seeing how they did labour and that. This wimmin was actually standing up having her bairn."
(Participant, Focus Group D)

4.6.2 Attendance of Antenatal Classes

None of the lower ACORN residents attended antenatal classes or completed birth plans. All of the higher ACORN residents, sampled for the focus groups, attended antenatal classes. Two of the most frequented classes are those run by the National Childbirth Trust (NCT) and the NHS. Twenty two focus group participants attended antenatal classes with six of these participants additionally attending NCT classes. Both classes offer information on all aspects of antenatal care and labour, describing the different options available to the women regarding pain relief, breathing exercises and feeding methods.

Those attending both NHS classes and NCT classes perceive the difference between the two as the latter concerning itself with the emotions of the women and the former concentrating on the practical aspects of the Maternity process.

"The health centre ones they had [ran] *every week but a lot of it was just watching videos and watching how to make up formula."*
(Novice Participant, Focus Group C)

"They were all pretty basic really [NHS antenatal classes]".
(Novice Participant, Focus Group A)

"There were six antenatal classes and most of them were on safety. I can't say I learnt anything new."
(Novice Participant, Pilot Group)

Furthermore, using the data provided by the focus group participants who attended both NHS and NCT classes, it can also be assumed the NCT counsel the women significantly on the merits of breast feeding and the difficulties these women can encounter by choosing this option.

"If I hadn't been to the NCT I would have been very disappointed about the breast feeding - because I don't think I would have coped very well."
(Novice Participant, Focus Group C)

"I would have gone stark raving mad without the NCT. I probably wouldn't have been able to breast feed either."
(Expert Participant, Focus Group C)

4.6.3 Rationale for Attending Antenatal Classes

Focus group participants communicated they attended antenatal classes for a number of reasons, not only to receive information but often to learn of the experiences of other women and to form friendships.

"The best thing I would say about it (antenatal classes) *is that I know people like Carol and Moira. I've got really good friends now who were in my class. It's the socialising more than anything."*
(Novice Participant, Focus Group C)

"I went to the ones [antenatal classes] *at the clinic. It's a great way to get to know people. You really need that when you're a first time Mum."*
(Novice Participant, Focus Group E)

Therefore, the antenatal classes provided not only scope to develop expectations but also the opportunity to extend the boundaries of referent groups.

4.6.4 Rationale for not attending Antenatal Classes

The intensity of expectations increased for higher ACORN residents during the antenatal period as they attended antenatal classes and immersed themselves in information on pregnancy and birth. However, lower ACORN residents typically demonstrated non-attendance of antenatal classes and infrequent, if any, reading of books magazines or leaflets.

"I've got three and a never went [to antenatal classes]. *At the time you're no in control - so you wouldnae use it* [the information] *anyway*."
(Expert Participant, Focus Group F)

"Who is wanting to go when you haven't got a husband and everybody else has - and you are sitting there by yersel?"
(Novice Participant, Focus Group D)

The data which arose from the discussions within the focus groups, suggested the participants residing in lower ACORN groupings, are familiar with details of childbirth on an anecdotal or word-of-mouth basis (See **4.6.7**).

The focus group participants residing in lower ACORN groupings expressed their unwillingness to explore thoughts, feelings or opinions before attending the hospital in childbirth by using repetition of the phrase *"you'll find out soon enough"*. This unwillingness to discuss expectations may also have been attributed to the participants' lack of awareness of the technicalities of the obstetrics process (See **2.4.8.4**).

Focusing on antenatal classes specifically, the participants from the lower ACORN areas were encouraged to express their reasons for non-attendance. Considering a number of variables, the moderator probed this area to extract traces of anticipation or preparation for either the labour or postnatal period.

Two main elements arose from the discussion regarding antenatal classes. Initially the participants expressed a consistently negative attitude towards the classes, describing them as places for (a) married couples and (b) couples interested in learning how to breathe regularly and effectively through labour.

"My idea of it is that you [are] *sitting on the floor with the father doing breathing lessons and all. I thought it was for married people."*
(Novice Participant, Focus Group F)

A general consensus of this idea was apparent, as other focus group participants nodded or added vocal support. The majority of these participants were either living with a partner or living on their own. Perceiving panting or breathing as a

fundamental element of the antenatal classes, participants communicated they would have felt awkward and uncomfortable were they to function in this environment.

4.6.4.1 Transportation Problems

Suggesting antenatal classes held information on a variety of issues, not least breathing exercises, the moderator exposed a previously undiscovered element, key to the functioning of these participants. The focus group members began to express difficulty in attending, not only antenatal classes, but antenatal appointments at the hospital because of transportation problems.

"I lived at Clermiston at the time and my antenatal classes were at the Royal. Weren't they all at the Royal? And who is going to get on a bus to go away up to the Royal Infirmary at night time when yer on yer ane[own]*? Especially at wintertime when yer pregnant."*
(Novice Participant, Focus Group D)

Focus group members, specifically from lower ACORN residential areas, voiced extreme difficulty in mobility, using this as another significant reason for non-attendance of antenatal classes.

4.6.5 Use of Birth Plans

Two types of maternity plan exist: the individual care plan and the birth plan. The first is a plan which incorporates the overall obstetrics process with the second concentrating on the labour period only. As a result, the plan which focuses only on labour, is more frequently used as it is both:

- easier to complete
- easier to follow, providing continuity of care

The *birth plan* is a small document, given out by the hospital and completed by the women before arriving at the hospital during labour. It details the preferences of the individual regarding the birth of their child, perhaps containing information on the position the woman would prefer to adopt and/or pain relief the woman would prefer to receive.

The birth plan is not an essential document as the women are not expected to complete this information before going into hospital. It is, however, mentioned during this section as the focus group participants attending NCT classes discussed utilising these documents extensively in comparison to other focus group members.

"The NCT did a whole class on birth plans which was very helpful. There was a tiny bit [about birth plans] *in the NHS classes because of the birth plan at the back of the Simpson's booklet."*
(Novice Participant, Focus Group C)

Residents in lower ACORN areas were less likely to be familiar with a birth plan and typically did not complete a birth plan because *"it's a waste of time"*. These respondents believed they did not know what was going to happen to them during labour and as such did not use this opportunity to express their wishes.

4.6.6 Varying Use of Literature

Higher ACORN residents, within this sample, demonstrated a heavy consumption of literature in comparison to those from lower ACORN areas. The focus group participants from higher ACORN areas were able to name reference books, authors and magazines which focus group participants residing in lower ACORN areas were unable to do.

"I read Miriam Stoppard - that sort of thing. I had five or six guides to pregnancy. I probably over-read."
(Novice Participant, Pilot Group, Higher ACORN)

"I read everything and anything! I read a lot of those parenting magazines and I still read them now."
(Novice Participant, Focus Group E, Higher ACORN)

"Nut [no - did not refer to the literature]. *When you read things you start imagining stuff, eh? Things that can go wrong and things that can happen."*
(Expert Participant, Focus Group F, Lower ACORN)

The knowledge of higher ACORN residents became apparent through the consistency of information given by these focus group participants. Awareness of DOMINO and a desire to utilise this opportunity was expressed only by these focus group participants. DOMINO, as explained in the *Provision of Maternity Services in Scotland* (1993), is an acronym for Domicilary In and Out. In this scheme, the woman receives care from the community midwife through all stages of care. When labour commences, the midwife will assess the progress, take the woman to hospital, deliver her baby and accompany her home again - usually about six hours after the birth. DOMINO was not an issue raised by focus group participants in lower ACORN residences.

As the discussions progressed, amongst the participants from higher ACORN areas, they became increasingly concerned that DOMINO was not available to them in their area. This was a result of resources being unavailable to support such a scheme. This concern was demonstrated by the continuation of the theme by the participants and was perhaps aided by the influence the participants were having on one another.

Similar information became available to all focus group participants as they were all issued with a comprehensive guide to pregnancy and birth, by their chosen hospital, at their first antenatal visit. This visit typically occurs within the first

twelve weeks of pregnancy. Therefore all groups had an equal opportunity to become immersed in the literature. However, focus group members residing in lower ACORN areas read infrequently. If they read at all they read small pieces of information concerning their condition.

4.6.7 Increased Use of Informal Referent Groups

As a result of non-attendance at antenatal classes and infrequent, if any, reference to literature, focus group participants residing in lower ACORN groupings utilised their informal referent groups to a greater extent than the participants residing in higher ACORN areas.

"Ma younger sister she haemorrhaged. She went from red to grey in minutes."
(Novice Participant, Focus Group D)

"Ma pal had the amniocentesis and they told her the baby had spinabifida and aw that and she was 21 weeks pregnant and ye have to go through the delivery. They said take this tablet and come back on Wednesday. This prepares yer cervix. This was Monday. They sent her out the hospital and there was no after care. Nae follow up."
(Expert Participant, Focus Group F)

Novices and experts residing in lower ACORN areas largely developed their expectations from the experiences of individuals known to them, and did not go beyond these realms of insight.

4.7 LABOUR ISSUES

Discussions on, and perceptions of, the labour period were varied. Specific issues appeared to be of significance to certain focus group participants. These issues were attributable to the residential areas of the focus group members expressing

their views on the maternity provision. These issues are explored below and the differences between the focus group participants are highlighted.

4.7.1 Labour

The knowledge of higher ACORN residents extended beyond type of childbirth opportunities and incorporated details of pain relief medicine and, to varying degrees, their effects on mother and child.

"I didn't have a really strict birth plan - I just said I didn't want an epidural under any circumstances. I didn't want pethadine because I heard it was rubbish. I wanted diamorphine."
(Novice Participant, Focus Group B)

"Nobody said what was best or how drunk you would feel after the drugs...what kind of effect its going to have on you and how sleepy you and the baby are going to be."
(Novice Participant, Pilot Group)

"She [the midwife] *really wanted me to have an epidural and I really didn't want one - mostly because I'd read up on the side effects of it."*
(Expert Participant, Focus Group E)

These specific participants, through information acquired from antenatal classes, literature and referent groups, demonstrated their ability to determine their choice of pain relief during childbirth. Pain relief is a topic raised during antenatal classes and specifically within the birth plan and is therefore considered by these focus group members before labour.

Typically, participants residing in higher ACORN areas, who chose to have pain relief, expected that:

(i) The pain relief requested on the birth plan would be the medicine received
(ii) The timing of the pain relief would adequately cover the period of pain

Some participants recorded handing in birth plans on arrival at the hospital and these plans were either filed and not referred to or only referred to by the first shift of midwives.

"I knew for a fact it was in amongst my notes because I could see it but they never mentioned it."
(Novice Participant, Focus Group E)

"The thing that annoyed me during the birth was the number of midwives I went through. I must of had at least six different midwives. Not more than a couple referred to it [birth plan]*".*
(Novice Participant, Focus Group B)

Consequently, when the labour continued through a variety of shift patterns, the women either became repetitive about their chosen pain relief or gave the responsibility to those conducting the treatment. The difficulties that arose from this scenario were not from a lack of expectation but were as a result of fixed expectation, developed during the antenatal period. These incidences were reflected by novices only.

"I filled it in all right but the minute I gave it to the nurse she came straight back with it. She said "see this bit here" - it was the bit about having an episiotomy - I didn't want one at all. She said... "there's every possibility we would have to do one". I said "OK, as a last resort" and she scored it out. I felt she just looked at it and thought I'm not having this."
(Novice Participant, Focus Group B)

Participants residing in lower ACORN areas communicated few, if any, expectations of labour other than pain and only mentioned pain relief tentatively. However, the referent groups of the participants residing in lower ACORN areas featured especially during the focus group discussions on labour. Lower ACORN focus group participants contrasted significantly with focus group members from higher ACORN residences as they utilised support from mothers, sisters and female friends, during labour, contrary to the use of partners by the latter focus group participants. Little or no distinction between the labour expectations of novice and experts resident in lower ACORN residential classifications were apparent.

4.7.2 The Unreliability of Childbirth

Childbirth and its unreliability continued to provide problems for both novices and experts residing in higher ACORN residences. Expectations centred on the belief that the administering of pain relief would alleviate discomfort for the duration of labour. Twenty six of the focus group participants, especially novices, were surprised not only by the discomfort they felt but additionally by the monitoring of drug administration. In some cases, the participants felt they had requested relief at too early a stage in the duration of their labour, allowing themselves an inadequate supply at perhaps a more crucial stage of labour.

"*At the hospital I had Fraser* [first child] *in they didn't give epidurals - which was worse* [than having a cocktail of drugs]. *They gave pethadine but it wasn't until you were in labour, and they had given you the pethadine, that they told you you had had your pethadine and you couldn't have anymore. And there was nothing else they could give you.*"
(Expert Participant, Focus Group C)

Focus group participants experiencing these difficulties notably recorded being ill-informed and slightly disappointed as a result.

Eight novices expressed inadequate preparation for the unreliability of childbirth although they had read extensively and attended antenatal classes. Several incidents throughout the data suggest that although the birth plan, and certainly current literature, assist in developing an insight into what *may* happen to individuals during childbirth, little emphasis is placed on the problems which can and do occur.

"When I was pregnant with Emily, there was a programme on the telly that dealt with things that could go wrong - handicap, the baby dying and how to cope with all these things. Although it was very sad to have to watch it, I felt a lot more prepared if things did happen."
(Expert Participant, Focus Group E)

Regardless of attendance at antenatal classes and the immersion in current data, two individuals who could be categorised as being most well informed, reported the greatest disappointment when their expectations remained unfulfilled; their expectation being a normal delivery and the outcome resulting in an emergency caesarean section.

"The only reason I want another baby is so that I can go through labour. I came out and I was crying for months afterwards. I was in a terrible state. I was really disappointed. I had really strong expectations of how I wanted the labour to be and when I was in labour I was completely at their mercy." [This focus group participant had an emergency caesarean]
(Novice Participant, Focus Group C)

This indicates that although these participants, residing in higher ACORN areas, had fully developed expectations they were not excluded from preconceived ideas or unfulfilled expectations.

Pain relief became less of an issue for six focus group participants residing in higher ACORN areas as they either required milder forms of pain relief or alternative types of pain relief. Three participants specifically utilised only Gas and

Air, which is self administered, or a TENS (Transcutaneous Electrical Nerve Stimulation) machine which is strapped onto the woman during childbirth, and passes tiny electrical impulses onto the skin to distract the nervous system from feeling pain. Notably, these participants reported their experiences positively and although the participants were not exclusively experts, the majority reflected this category.

4.7.3 Transportation Problems

Transportation problems continued into the labour period with two participants residing in lower ACORN areas indicating they had difficulty in attending the hospital during labour.

"Yeh, they never ask ye if you've got any transport...She never said do you want an ambulance or do you have transport or anything. She just said make your way up here."
(Novice Participant, Focus Group D)

"They just telt me to go up [go to the hospital]."
(Expert Participant, Focus Group D)

"I just get on the bus."
(Expert Participant, Focus Group D)

Compounding this difficulty may have been the participants' perceptions of their first telephone call to the hospital. Before making the initial telephone call, the participants expected to be offered transport to the hospital. Once completing this call, however, these focus group members considered they were expected to find their own transport to the hospital whilst in labour.

Transport was an issue raised by the focus groups. The Ambulance Services, in the Patient's Charter, detail their targets for reaching an emergency. If the emergency is resident in an urban area, the target time for reaching that

emergency is 14 minutes. In rural areas, the target time is 19 minutes. However, the emphasis is on *emergency* and the service is there for *people in the most urgent need of hospital treatment*. Routine labour is not considered to be an emergency if the women is healthy and is +37 weeks gestation. Throughout the antenatal period, a woman will be encouraged to prepare for labour and this will include packing a bag for the hospital and deciding how the hospital will be reached during labour. A woman in labour would only be considered an emergency, if, for example, she was less than 37 weeks pregnant and was haemorrhaging.

As such, the participants in the focus groups, who were resident in lower socio-economic groupings and were unsure of transport arrangements, would have benefited from a better level of communication between themselves and the formal referent groups. The formal referent groups would have clear information on transportation arrangements for women during labour.

4.7.4 Use of Informal Referent Groups

Although four focus group participants residing in lower ACORN areas involved their partners during labour, mothers, sisters and friends communicated additional knowledge and support which their partners were unable to provide.

"Aye, Neil, he'd done a disappearing act, eh? So ma sister came in wi' me. He got a lan [loan] *of somebody's bike and cycled aw the way to the hospital. When he came she went away - but she kept phoning every ten minutes. Has she had the bairn yet? Has she had the bairn yet?"*
(Expert Participant, Focus Group D)

The utilisation and alliance of these informal referent groups predominated the discussions, establishing that participants residing in lower ACORN areas developed expectations utilised support through word of mouth.

4.8 POSTNATAL ISSUES

The postnatal experiences communicated by the focus group members centred on the postnatal stay in hospital only. The experiences centred on length of postnatal stay, cleanliness, the significance of staff /patient relationships and visiting hours. The differences between the perceptions of focus group participants is explored in the following section.

4.8.1 Postnatal Perceptions

Expectations and perceptions of the initial postnatal period at home were not recorded. This is a limitation of the research as the length of stay in hospital varied between the participants from varying residential areas and was dependent on the health of the baby and the parity of the participant. As such, the contribution some participants could make was limited to their time in hospital. This sample included participants who only stayed in hospital for twenty four hours.

4.8.2 Length of Postnatal Stay

The first of postnatal topics, namely length of time participants spent in hospital after the birth of their child, rather reflects the view of novices. Typically, experts spend a far shorter period in hospital with second and subsequent children, particularly if both the mother and child are enjoying good health. This reinforces the confidence of experts which develops with experience.

Novices residing in higher ACORN areas usually stayed in hospital for five days after giving birth. This period allows the mother to recover, also giving the baby an opportunity to develop under constant monitoring. Four novices residing in higher ACORN areas focused on the support they received during breast feeding as a reason for their length of stay in hospital.

"If I wasn't going to leave hospital the day I did, I could have had a day pass and left the hospital. They were quite good about things like that. I was in a week. I would have stayed longer."
(Novice Participant, Focus Group A)

The majority of novices further reported feeling "safe" whilst remaining in hospital, their expectations being concerned with the health of the child and proximity of an "expert" to assist if problems arose.

Typically, the focus group participants residing in lower ACORN residences reported their length of stay in hospital as two to three days. This length of stay reflected both the behaviour of the novices and experts.

"I was only in two nights. [It was] too long. I would of left the minute I'd had him."
(Novice Participant, Focus Group D)

"With the second yin I was only in a night. I just dinny like hospitals."
(Expert Participant, Focus Group D)

"I was in too long. A was only in three days an' a had tae get oot."
(Novice Participant, Focus Group F)

The discussion on the postnatal stay in hospital included perceptions on staff attitude.

"I find the doctors in the hospital are sarcastic tae ye. When I went in they said I was in labour but that it would wear off. He said "You'll be away home tomorrow." I met him two days later and he said "Are you still here?" and I said "Aye. Cos I had her [the baby] *the following day.""*
(Novice Participant, Focus Group D)

"During the night your no allowed to walk anywhere."
(Expert Participant, Focus Group D)

The data indicated that lower ACORN residents spent less time in hospital because they perceived:

(i) The staff, particularly the consultants, patronised them
(ii) They were closely monitored, making them feel uncomfortable
(iii) The limitations of visiting hours compounded feelings of isolation

As a result, these focus group members experienced poorer patient/staff relationships. When the staff advised a particular course of action, the participants resident in lower ACORN areas, perceived that the staff considered them to be "stupid".

"It was that "Ye shouldnae let a new-born baby sleep for five hours" and I said "Are you gonna wake him up cos I amnae"" [am not].
(Novice Participant, Focus Group D)

In addition, the discussion highlighted that constant health monitoring by the staff resulted in the participants feeling that there was a lack of privacy. This compounded the uncomfortable feelings of the participants which consequently shortened the length of stay in hospital for these particular women.

Clearly utilising the support of women from similar residential areas continued throughout the postnatal stay in hospital. Lower ACORN residents and visitors assisted one another by baby-sitting to allow both smoking and bathing interludes.

"Ken like if ye like a smoke yersel yer no wanting tae sit for a whole visit. A had ma Ma and ma Auntie looking after the bairn while I was in the smoking room."
(Novice Participant, Focus Group F)

However, these focus group participants' did not breast feed their infants and their length of stay in hospital was shorter than that of the focus group

participants residing in higher ACORN areas. This perhaps lessened the necessity for support from the medical staff.

4.8.3 Cleanliness and Hygiene

Whilst the focus group members residing in higher ACORN areas expressed that their initial excitement overcame the majority of anxieties concerning cleanliness, the length of recuperation in hospital allowed the focus group members to become discerning. Novices, on occasion, through the use of referent groups, brought cleaning fluids and equipment into the hospital to clean the facilities before use.

"I had a bath but I had to clean it out first"
(Novice Participant, Focus Group A, Higher ACORN)

"I ended up bringing in a bottle of dettox to clean the loo myself"
(Expert Participant, Focus Group E, Higher ACORN)

Therefore, their expectations of cleanliness, before arriving at the hospital were low. In addition, novices' use of referent groups is apparent through the developing of these specific expectations and highlights a greater utilisation of these groups than suggested by East (1993).

Experts, through previous experience, and to a lesser extent through their use of referent groups, regarded cleanliness with similar concern as the novices. However, experts further considered their length of stay in hospital inadequate to fully assess the cleanliness and hygiene of their chosen maternity units.

The nature of this study is heterogeneous and sampled a wide variety of individuals with extremely different habits and degrees of hygiene. The acceptability of cleanliness, then, may cross cultural and residential groupings to a greater extent than the analysis of these focus groups has demonstrated.

Focus group members residing in lower ACORN residential classifications were also questioned regarding the cleanliness of the hospital during their postnatal experience. Albeit, these participants stay in hospital was shorter than that of the focus group members residing in higher ACORN areas, these focus group participants remained impartial to questioning, and blandly reported the hygiene standards were *"fine"* or *"OK"*.

4.8.4 The Significance of Staff / Patient Relationships

A number of focus group participants commented on incidents they witnessed between staff and patients whilst they were on the postnatal ward. These incidents negatively affected the participants' overall perceptions of their service experience and, even though the incidents did not directly involve them, the participants were concerned about the behaviour they had witnessed. The recognition and distaste of these incidents were not confined to any one group of participants.

"There was a sixteen year old girl and she was hysterical and crying for her Mum. They were telling her to shut up and I just wanted to give her a cuddle. I had a sixteen year old daughter at the time myself."
(Expert Participant, Focus Group E, Higher ACORN)

"This lassie was roaring and greeting [crying] over this baby and they were actually in with the guns firing and I was like "Here!". I couldnae believe the nurses were actually bawling and shouting at her"
(Novice Participant, Focus Group D, Lower ACORN)

"Another night I was sitting there [in the nursery] *and the nurses started to talk about one of the patients who had just left. I felt really uncomfortable because she was in the bed next to me in the ward. All I could think was I wonder what they are saying about me when I'm not here."*
(Novice Participant, Focus Group A, Higher ACORN)

Additionally, staff/staff relationships also affected the overall perception of the postnatal stay.

"It's the night shift versus the day shift."
(Novice Participant, Focus Group A, Higher ACORN)

As the judgement of quality is typically based on the climate of the relationship between the organisation and its consumers (Bonaccorsi & Fiorentino, 1998) a positive relationship between staff and patients is a necessity, as is staff/staff relationship for an overall positive service experience.

4.8.5 Visiting Hours

An issue which dominated the closing discussions of all focus groups was varying expectations towards visitors and visiting hours. Views and perceptions of the focus group participants produced a diversity of opinion which could be attributed to residential grouping. The higher ACORN residents, participating in the focus groups, communicated the following:

(i) Visiting hours were too long and not adequately monitored
(ii) The length of visiting added to the fatigue of the mothers
(iii) Visitors generally spoke to one another rather than to the patient

"I found it really tiring because I've got a big family...By the end of the night I wished I'd had half an hour to myself."
(Expert Participant, Focus Group B, Higher ACORN)

"The last night I was there, there was a new girl who had 15 people round her bed and I had five. Luckily the nurses felt they had to say something!"
(Novice Participant, Focus Group A, Higher ACORN)

This postnatal topic reflected the views of both the novices and experts, but clearly affected the novices extensively, as their longer length of stay in hospital

dictated an increased volume of visitors. The participants, not surprisingly remained unconcerned regarding opening times for partners and husbands.

Focus group participants resident in higher ACORN areas, considered visiting hours for peripheral family and friends to be lengthy, with little time for the mothers to compose and rest between afternoon and evening visits. The participants also mentioned difficulties with other patient's visitors as well as their own, as the noise and general atmosphere added to the fatigue of the participants.

Infrequent or no intervention by the nurses, whose respect for privacy the participants had previously admired, attributed to the visiting dilemma for these focus group members. The social nature of the participants prevented them from requesting time alone during visiting times. Participants also recorded, on numerous occasions, the visitors conversed with one another and not the patient; leading the participant to question the purpose of visiting times.

In contrast, focus group members residing in lower ACORN areas typically expressed their enjoyment of visiting hours, suggesting the visiting hours should not be limited. Often, these participants would describe isolation and lack of communication during quiet periods in the hospital, in comparison to colourful visiting hours.

A like tae talk.
(Novice Participant, Focus Group D, Lower ACORN)

Similarly, with the expectation that visiting hours would be open on request, and this expectation remaining unfulfilled, these focus group participants decided to leave hospital to regain an unlimited source of support at home with minimal monitoring and intervention.

"The night after ma wee one was born, ma family came in and the nurse came up and said "You canny have this, your family will have to go out. We can't have more than two to a bed"".

(Novice Participant, Focus Group F, Lower ACORN)

Other focus group members believed that visitors were part of their support and recovery,

"They had nae choice wi ma visitors. As long as they dinny run aboot."
(Novice Participant, Focus Group D, Lower ACORN)

Summary

Within this chapter, two main sections were identified. Initially, the similarities in opinion amongst all focus group members were discussed. These similarities spanned a number of issues, including: choice of hospital, hospital food, antenatal appointments, postnatal ward information, nursery provision and hospital security.

Distinct differences in opinion amongst the focus group members were also apparent. Antenatal class attendance, use of available literature, use of informal referent groups, length of postnatal stay, staff/patient relationships and visiting hours were discussed within all seven focus groups and produced significant differences in opinion. These differences were attributed to the cultural and social diversity of the focus group participants. The varying perceptions of novices and experts was also an issue which arose and was further explored throughout the remaining stages of this research.

The next chapter outlines the in-depth interviews, using a new sample of women. This was to ascertain if the findings of the focus groups, before and after the birth, could be substantiated.

CHAPTER FIVE

5.1 INTRODUCTION

Chapter three discussed the methodology used for this second stage of the empirical research, illustrating the techniques employed to substantiate or discount the analysis resulting from the focus group discussions. The analysis of the in-depth interviews presented in this chapter replicates the format used for the focus groups, utilising *Framework*, developed by Ritchie and Spencer (1994).

For ease of comprehension, the interview analysis is presented in two sections, with the first of these sections detailing the responses of the "novice" interviewees. The definition of a novice interviewee, for the purpose of this research, is a woman expecting her first child. The presentation of this analysis is further developed as discussion of the results fall neatly into three categories: antenatal expectations and perceptions, expectations and perceptions of the labour period, and expectations and perceptions of the postnatal stay in hospital.

The responses of "expert" interviewees, women expecting their second or subsequent child, are presented in the second section of this chapter. The format for presentation of results mirrors that of the first section.

The in-depth interview analysis concentrates on confirming or discounting the findings of the first stage of empirical research. As such, the findings are presented under the headings of the salient issues raised within the semi-structured interviews. These salient issues, which are manifest in Table **5.1**, include recurrent ideas on waiting times, hospital facilities and postnatal perceptions of medical support.

Issues Concerning the Antenatal Period	Issues Concerning the Labour Period	Issues Concerning the Postnatal Period
• Choice of Hospital • Length of Waiting Times • Attendance of antenatal classes • Antenatal referent groups • Literature as a source of information • Expectations of the Patient's Charter	• Medical staff as experts • Expectations of labour & pain relief • Perceptions of childbirth • Availability of staff during the labour period • Role of Partner	• Expectations of security • Hospital facilities • Ward sizes • Perceptions of Postnatal Stay • Postnatal support • Perceptions of the Patient's Charter

Table 5.1: Salient Issues Raised During In-Depth Interviews

5.2 OVERVIEW OF INTERVIEW METHODOLOGY

Building on information gathered from the focus group analysis, the in-depth interview questions concentrated on expectations, experience and referent groups. These questions were asked before and after the respondents gave birth. (For questions see: Appendix 3(a) & 3(b)). This section concentrates on the results of the in-depth interviews and considers the issues pertinent to the research objectives.

As each respondent was interviewed twice, each interview began with a brief resume, detailing this study and outlining the integral contribution provided by the interviewee. During the initial interview the resume was to inform the respondent of the nature of the study. The resume used in the second interview, usually

conducted within three months of the first interview, was merely to remind the respondent of their role. The request to use the recording equipment was also made at this juncture.

Interviewee comfort was established during this stage. For participants with children, provision was made to occupy the offspring to minimise disruption. The initial interview questions were rapport building (Webb, 1992) and the wording of the questions were intended to be familiar to the participant. These first questions were to establish the use of referent groups. Referent groups, as indicated in the conceptual framework (Figure **3.1**), are influential throughout the antenatal period, labour and the postnatal period.

The in-depth interviews were categorised by parity and this resulted in:

(i) antenatal & postnatal interviews for pregnant women with no other children

(ii) antenatal & postnatal interviews for pregnant women with one or subsequent children.

This maintained the focus on the categories of novice and expert participant as illustrated in chapter three (See **3.2.1**) and described by East (1993). The significance of East's categorisations is based on experience and the use of the key construct of knowledge. The interviews, therefore, were designed to measure the extent to which experience affected perception.

Before presenting the findings of the in-depth interviews it is appropriate to highlight that the interviewees' greatest expectation, and priority, during the antenatal period was a healthy baby. This was true of all interviewees, regardless of experience or residential grouping. This priority was reiterated on numerous occasions during the antenatal interviews with countless repetitions of a desire for a healthy child.

During the postnatal interviews however, when all the interviewees had produced live, healthy children, the focus of the responses changed to service quality issues (Berry, Zeithaml & Parasuraman, 1990). The "before" and "after" measurement of the interviews demonstrated that the interviewees had, not only varying priorities and expectations of service, but that these priorities were subject to change during different periods of the overall process. These expectations and perceptions are discussed throughout the following sections and a summary of the ***novice*** responses is manifest in Tables **5.2, 5.3** & **5.4**.

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
GPs to choose hospital for birth	Service differences apparent between hospitals	GPs to choose hospital for birth	Service differences apparent between hospitals	+
Waiting for antenatal appointments	Were seen on time	Waiting for antenatal appointments	Were seen on time	Contradicted findings of the focus group
Completed birth plans and attendance at antenatal classes	Birth plans not fully utilized and unreliability of childbirth surprising	Non-completion of birth plans and non attendance at antenatal classes	Less surprise at the unreliability of childbirth	+
Use of formal referent groups as a reliable source of information	Credible information given by medical professionals	Use of informal referent groups as a reliable source of information	Information given by family, friends and peer group most reliable	+
Literature used as a source of information	Useful reference tool for minor queries	Literature used infrequently if at all	Regarded as an additional option	+

Original in colour

Table 5.2: A Summary of Novice Interview Responses Relating to the Antenatal Period

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
The medical professionals would be experts in their field	Women gave the medical professionals responsibility for the birth	The medical professionals would be experts in their field	Women gave the medical professionals responsibility for the birth	+
Women had requested specific pain relieving drugs	Childbirth was unreliable and the pain relief sporadic	Women had expectations of pain but not of specific pain relieving drugs	Difficulties arose when the terminology for specific drugs could not be remembered by the patient	+
Staff would be available throughout labour	Staff were continually present	Staff would be available throughout labour	Staff were continually present	Contradicted findings of the focus group
Role of the partner varied	Role of the partner varied	Role of the partner varied	Role of the partner varied	Contradicted findings of the focus group

Original in colour

Table 5.3: A Summary of Novice Interview Responses Relating to the Labour Period

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
Realised it was difficult to constantly secure the wards	Considered security to be adequate	Expected security to be a priority	Considered security to be adequate	Contradicted findings of the focus group
Prepared to take cleaning fluids into hospital	Varied with different maternity units	Expected cleanliness and hygiene to be acceptable	Varied with different maternity units	Inconclusive
Food a low priority	Hospital food poor	Prepared to have food brought in to the hospital	Hospital food poor	+
To stay in hospital as long as necessary	Typically stayed in hospital for five days for support	To leave hospital as soon as possible	Perceived breast feeding mothers received more support	+

Original in colour

Table 5.4: A Summary of Novice Interview Responses Relating to the Postnatal Period

5.3 NOVICE EXPECTATIONS & PERCEPTIONS OF THE ANTENATAL PERIOD

5.3.1 Choice of Hospital

Antenatal Findings

The focus group members, during the previous exploratory stage, suggested they did not make an informed choice as to which hospital they would give birth in. The novice antenatal interviewees confirmed this finding and demonstrated their dependence on their GP to select a maternity unit for them.

Invariably the maternity units chosen for the interviewees were closest to their homes and the interviewees, during their antenatal period, could not be drawn into discussion on why they had not become more active in their choice of hospital.

The difficulty in obtaining this information from the novice interviewees could have been attributed to the interviewees' experience of hospitals. Only two of the ten interviewees had recently been in hospital, with the majority of others not having been in hospital since they had their tonsils removed, some fifteen to twenty years previously. Obviously some interviewees had visited family members and friends in hospital but these visits had been sporadic and incorporated many different hospital departments and a variety of hospitals. As a result, their experience of hospitals was not consistent, and the depth of experience was absent.

Novice interviewees residing in higher ACORN residences were aware of their ability to choose the hospital in which they gave birth, even though this option was not utilised. Novice antenatal interviewees residing in lower ACORN residences indicated they were unaware they had the ability to choose the hospital in which they were to give birth.

Postnatal Analysis of Choice of Hospital

One of the marked differences which arose from the "before" and "after" interviews was the interviewees' perception that the service levels varied depending on the choice of hospital. Before attending the hospitals during labour, the interviewees considered the choice of hospital to be unimportant. Indeed, the most prominent reasons given for attending one maternity unit over another, was the distance between the interviewee's home and the hospital. However, as the postnatal interviews were conducted and questions on service levels were raised, the interviewees produced responses which identified distinct differences between hospitals with varying hospital categories. These categories are identified in Chapter Three and are considered in Table **3.12**.

Interviewees, regardless of residential classification, identified service differences amongst the hospitals they utilised for childbirth. The novice interviewees, in this sample, attended maternity units which were able to provide, at least, a caesarean section should the need arise.

Substantial differences between Category 2 and Category 3 hospitals were identified in the following areas: ward sizes, cleanliness, security and availability of nursing staff. The variance identified in the service provision favoured the Category 2 hospital. These variations in service provision will be discussed at length during the analysis of postnatal stay in hospital (See: **5.5.6**).

5.3.2 Length of Waiting Times for Antenatal Appointments

The novice antenatal interviewees, according to their responses, were not kept waiting for appointments at either the GP surgery or the hospital. This directly contradicted the findings of the focus group which suggested women using the obstetric services were often kept waiting, particularly at the hospital, for antenatal

appointments. This contradiction of previous findings may have arisen as a result of:

(a) the variety of GP surgeries

(b) lack of responsibility for offspring

GP surgeries vary for a number of reasons, not least that GPs themselves are heterogeneous and treat patients differently. As a result some GPs concentrate on consulting with the majority of patients on time, whereas other GPs may wish to focus on the current patient and would appear to demonstrate less concern for patients in the waiting room.

Perceptions of Waiting for Appointments

The antenatal novice interviewees in this sample recorded no difficulties with making antenatal appointments and/or waiting times for these consultations. The possibility exists that their particular GPs or Consultants were conscientious of waiting times and the focus group members experienced GPs and Consultants who concerned themselves with their current patient.

Conversely the expert interviewees, during their antenatal interviews, indicated they were kept waiting for long periods of time for antenatal appointments. The perception of the novice antenatal interviewees could be a result of the relationship between delays and evaluations of service.

As the novice antenatal sample lack responsibility for other offspring, the possibility exists that their perception of their wait for antenatal appointments varies extensively from that of their counterparts. Taylor (1994), citing Katz, Larson and Larson (1991) maintains service waits can be controlled by two techniques: either operations management or perceptions management. If, for example, the wait cannot be controlled by time management, the perception of the wait should be influenced by those providing the service.

To influence an individual's perception, the variables which generate the individual's thoughts towards the wait must be established. These variables, amongst others, may be comfortable surroundings, noise or current emotional state. It is possible that the perception of the novices and experts differ as a result of the variable of responsibility. Current empirical research in this area is limited (Clemmer & Schneider, 1989; Katz, Larson and Larson, 1992).

5.3.3 Completion of Birth Plans

Birth plans distributed during the antenatal hospital visits, and antenatal classes, afforded the greatest opportunity to establish or develop expectations for the labour period. The completion, or non-completion, of the birth plan by the individual interviewee, provided an accurate indication of expectations, or lack of expectation, for the labour period. The birth plan, as previously mentioned, is a short document for pregnant women to complete and for the medical staff to refer to during the labour of these pregnant women. The completed birth plan indicates the wishes of these women, for example, the preferred pain relief or preferred birthing position.

All the antenatal novice interviewees, resident in higher ACORN groupings, were familiar with birth plans. Although not every interviewee completed their birth plan, the majority stated that the format of the plan had allowed them to consider the options available to them during labour. These options had previously not been considered.

The interviewees resident in higher ACORN areas, who completed their birth plans did so by using the terminology "wait and see". This indicated not only their lack of experience in this situation, but also demonstrated difficulty in making decisions about the labour period. The completion of these birth plans were influenced by the "useful" or "trustworthy" referent groups who conducted the

antenatal classes. These midwives and specialists discussed with the antenatal novice interviewees the unreliability of the labour period and the disappointment some women had previously encountered when their birth plans could not be followed.

Well we were talking about it [birth plan] at antenatal classes and now I don't think there's any point [in completing a plan]. *She* [the midwife] *was saying it all goes out the window very quickly.*

(Novice Participant, Higher ACORN, A2)

Novice respondents resident in lower ACORN areas did not complete birth plans as they considered them to be ineffectual:

"Aw a need is a screen roond the bed and loads o' pain killers"

(Novice Participant, Lower ACORN, A4)

"Birth plan ha-ha. I'll have whatever is going"

(Novice Participant, Lower ACORN, A5)

5.3.4 Attendance of Antenatal Classes

Antenatal novice interviewees residing in lower ACORN residential areas confirmed the findings of the initial exploratory focus groups by stating they had not attended antenatal classes and nor had they completed birth plans. As previous findings also indicated, the single greatest reason for non-attendance of antenatal classes was the perception that the classes were for married couples who practised breathing exercises on a regular basis.

These particular interviewees were familiar with the unreliability of childbirth as they had experienced it at first hand, either with their mothers, sisters or friends.

As a result of their experience with the children of friends and family, or as a result of inadequate transport arrangements, or a combination of both, these interviewees did not attend antenatal classes or complete birth plans.

The unreliability of childbirth was apparent during the postnatal interviews with the novice mothers resident in higher ACORN classifications. The postnatal interview responses indicated the birth plans, which were completed and utilised during labour, did not go as planned. Interviewees who requested certain birthing positions or certain drugs did not have those expectations fulfilled.

I wrote one [a birth plan]. I had special appointments to see people and the buggers ignored it. I told them what I wanted and what I had agreed with the consultant. They gave me pethadine and I didn't want. I always wanted an epidural. I was totally numb - all the bonding was with my husband.

(Novice Participant, Higher ACORN, A1)

Childbirth, as experienced by two of the interviewees residing in higher ACORN residential areas, was disappointing as they had their children delivered by forceps. They clearly stated their lack of expectation had poorly prepared them for this outcome. The perception of the medical professionals as "experts", however, allowed the interviewees to attribute the choice and responsibility for the labour interventions to the midwives and consultants.

The postnatal interviews, with the novice interviewees residing in lower ACORN residential groupings, indicated that although this section of the sample appeared to have fewer expectations going into the labour period, the outcome resulted in few disappointments and no surprises for these interviewees. The terminology of these interviewees, regarding their imminent childbirth, was captured in the phrase "you'll find out soon enough". This phrase was used extensively during the antenatal interviews and mirrored the phraseology used by focus group members

of similar residential grouping. The lack of expectation and information, in these particular cases, provided these interviewees with a satisfactory labour outcome.

5.3.5 Antenatal Referent Groups

Pursuing the influence of referent groups, the interview format directly broached the topic of advice given to the interviewees during their pregnancies. The referent groups used by the interviewees were both formal and informal and all interviewees had contact with GPs, consultants, family members, peer groups and friends. Other referent groups included community midwives and specialists although these referent groups were typically accessed by interviewees attending antenatal classes.

Formal referent groups can be described as those individuals who have either professional qualifications or professional knowledge in their specialised field. In this case, individuals who work in the Maternity or Health Sector. The formal referent groups typically know the pregnant women on a formal basis and have a grounding on the medical background of the women. For the purpose of this study, literature was also considered as a source of information.

Informal referent groups are individuals, who may or may not have personal experience of pregnancy or childbirth. They are likely to be family, friends or peer groups who are known to the individual socially.

The antenatal novice interviewees, who attended public or private antenatal classes, stated the information received from their antenatal classes was both "useful" and "influential". Communication received during these classes was described as "reliable". The antenatal novice interviewees who attended antenatal classes were, as previously stated, those residing in higher ACORN residential groupings. These particular interviewees considered the antenatal classes to provide advice which could be relied upon. These interviewees considered the

advice from other sources, for example their mothers or informal referent groups, as "conflicting".

The interviewees themselves attributed this conflict of ideas to the variance in age of the informal referent groups and the social and cultural changes of different generations.

The distinct difference between the residential groupings appeared to be related to the attendance of antenatal classes. Interviewees resident in lower ACORN residential groupings utilised their informal referent groups to a substantially greater extent than their counterparts. As these interviewees demonstrated non-attendance of antenatal classes and non-completion of birth plans their opportunities to meet and be influenced by formal referent groups were reduced.

The behaviour and attitude of these lower ACORN interviewees reflected the established pattern of the focus group data and further illustrated profiles of mothers, sisters and friends "who have *bairns*" (children). Through the continued use of anecdotal accounts of the experience of their family and friends, the interviewees from these specific residential areas, demonstrated that their expectations of childbirth developed from the people socially closest to them.

These lower ACORN interviewees, however, maintained formal contact with both GPs and Consultants even though they did not attend antenatal classes. During antenatal appointments, the interviewees had the opportunity to ask for clarification on specific areas of the maternity process, should the need arise.

The interviewees residing in lower ACORN residential groupings maintained that the information they received from the medical professionals and the information they received from their informal referent groups was contradictory. The interviewees themselves considered this inconsistency to result from the age of the medical professionals. The respondents did not consider the information they were

given from the medical professionals to be incorrect but outdated. In contrast, the informal referent groups and their information was considered to be factual.

5.3.6 Literature As A Source of Information

Typically when a women is twelve weeks pregnant, in the Edinburgh area, she is "booked in" to the hospital where she will give birth. At this time she will be given a book, "Pregnancy and Childbirth", which is specifically produced to provide the women with an accurate guide to the overall process and experience of childbirth.

Novice antenatal interviewees residing in higher ACORN groupings were more likely to have read and digested this piece of literature and, usually, had accessed additional literature on the topic of childbirth. Respondents residing in lower ACORN groupings indicated they read very little or nothing on the topic of pregnancy or childbirth. Whilst one interviewee, resident in a lower ACORN grouping, responded that she bought parenting magazines occasionally; the remaining interviewees considered the literature to be unnecessary and added no value to their current awareness.

Statistics on levels of literacy and socio-economic groupings are not available as the National Statistics, produced by the government, consider employment types rather than socio-economic groups (National Statistics Office, 1999).

However, issues of literacy and women with special needs, from areas recognised as having multiple deprivation factors, have been considered (CRAG/SCOTMEG, 1995). The Women's Reproductive Health Service, based in Glasgow, believe that the most effective method of delivering basic antenatal education is to attach education to antenatal clinics. In their experience, the delivery of antenatal education must take into account lifestyle and behaviour. Opportunistic delivery of information should also be considered.

The antenatal respondents residing in lower ACORN groupings, on the same topic of information, illustrated their distaste at the promotional posters in the hospital, and GP surgeries, which encouraged breast feeding. These women considered breast feeding to be a choice or alternative to bottle feeding, although voiced their opinion that there was a greater emphasis on breast feeding. These interviewees also indicated their partners would find this feeding method unacceptable. Very few of the women interviewed were aware of anyone they knew who breast fed and none of the women interviewed in this sample intended to breast feed.

5.4 NOVICE EXPECTATIONS & PERCEPTIONS OF THE LABOUR PERIOD

5.4.1 Medical Staff as Experts

The novice interviewees, regardless of residential grouping, expected medical staff, in the hospital, to be experts in their field. Respondents cited the experience and the length of service of the medical professionals to justify the use of their terminology. This perception of "expert" reflects the findings of the focus group analysis.

The trust the interviewees placed in the "experts" was apparent when the interviewees were asked to consider their expectation of potential intervention during labour. Intervention during labour may, for example, involve forceps delivery or an episiotomy. The interviewees responded that the "experts" would decide if any intervention was necessary and that they did not have a preference as long as the baby was healthy.

All antenatal interviewees did have a preference within the "expert" category, however, as they unanimously trusted midwives more than any other medical professional. This preference was not gender related. These novice interviewees

again confirmed the perceptions of the focus group participants. The midwives, and their specific experience in the area of childbirth, was given as the main reason for the interviewees' preference.

Postnatal Perceptions of the Medical Professionals

The acceptance of intervention during labour, by the respondents, indicated the expectations of the medical staff, discussed by the novice interviewees during the antenatal period, were fulfilled. Although the term "expert" was less frequently used in the follow up interviews, the interviewees said they "reached a stage [where they] just wanted the baby out." Intervention became secondary, with the health of mother and child identified as the primary concern. The knowledge and expertise of the medical professionals was further recognised as central to the overall acceptance of intervention.

Perceptions of the medical professionals are further analysed in this chapter, whilst considering length of postnatal stay in hospital. (See: **5.5.6**).

5.4.2 Expectations & Perceptions of Pain Relief

The antenatal novice interviewees' expectations of labour evoked few responses other than pain and pain relief. Interviewees residing in higher ACORN groupings expressed the desire for specific pain relieving drugs or pain relieving equipment. These women asserted than upon receiving their requested method of pain relief, they expected to relax and become more comfortable. These same interviewees also indicated they held few expectations about their labour and repeated previous statements regarding the unreliability of childbirth.

Novice interviewees residing in lower ACORN groupings also held few expectations of labour other than pain.

Invariably, these interviewees, and their apparent lack of awareness of the functional aspects of labour, could be attributed to:

- The basis of their expectations being grounded in the experience of informal referent groups
- Non-attendance at antenatal classes, as this ensured these interviewees did not visit the labour suite before attending in labour
- Non-completion of birth plans and poor use of available literature during the antenatal period

The lack of awareness of the functional aspects of the labour period made the data collection on expectations of the labour period, for these specific interviewees, difficult. "You'll find out soon enough" were typical responses made by the respondents and guidance, by the interviewer, to particular aspects of the labour process were ignored.

Postnatal Perceptions of Childbirth

Novice interviewees residing in higher ACORN groupings indicated that although their labour had been a painful, it had been worthwhile. Intervention, in the form of forceps, episiotomies or both were necessary for these interviewees and varying levels of drug relief had been used by the respondents. These interviewees had attended antenatal classes, read the current literature available on the topic and had completed birth plans. However, they remained surprised at the unreliability of childbirth. Repetition of the phrase "I didn't expect that to happen" or "I wasn't expecting that" confirmed that although preparation had taken place, the extent to which novice interviewees could prepare for their childbirth had limitations.

Novice interviewees residing in lower ACORN groupings indicated they too had found labour to be a painful experience. Although the interviewees had appeared to be less prepared for their childbirth, none of these respondents demonstrated their surprise at childbirth through repetition of phrases or anecdotal recollections.

Accordingly, these interviewees indicated their labour largely reflected their expectations.

Non-attendance of antenatal classes and ineffectual utilisation of antenatal literature, however, poorly prepared these respondents for the technical terminology used throughout the labour process. Respondents, during labour, had difficulty requesting specific types of pain relief. In one case, an interviewee admitted she would have preferred an epidural but could not remember the technical term.

5.4.3 Availability of Staff During the Labour Period

All novice interviewees were accompanied throughout their labour by one or more members of the medical hospital staff. The presence of the midwife or nurse provided comfort to the novice interviewees and was regarded as a positive aspect of their overall experience. This finding contrasted with that of the focus group analysis as the focus group members said they were left on their own for long periods during their initial labour period.

The interviewees, with hindsight, commented that they had not expected to be left on their own during labour. This particular expectation was not exacted through the antenatal interviews. This may demonstrate a flaw in the interview format or, more simply, highlights the difficulty in ascertaining all the expectations of antenatal interviewees before they enter the labour and postnatal processes.

5.4.4 Role of Partners

The involvement of the partner *per se* was an issue raised by the interviewees and as such is recorded at this stage of the research. As previously indicated, however, a full or complete exploration of this topic, within this piece of research was unmanageable and too extensive.

During the focus group analysis, the involvement of the partner was considered to be *imperative* to focus group members residing in higher ACORN groupings. For focus group members residing in lower ACORN areas the involvement of the partner appeared to be far *less important*. Indeed, focus group members residing in lower ACORN areas indicated a preference for their sister, friend or mother to be present during labour as opposed to their partner.

However, the antenatal novice interviewees demonstrated that the role of the partner varied in importance and the degree of importance could not be directly attributed to the residential area in which the interviewee lived. Although the interviewees residing in lower ACORN areas maintained that they would prefer to have their sister, mother or friend with them during labour, two interviewees residing in higher ACORN areas admitted the same preference.

5.5 EXPECTATIONS & PERCEPTIONS OF THE POSTNATAL PERIOD

5.5.1 Expectations & Perceptions of Security

This particular area of discussion reflected a topical issue as the interviews took place in light of press conferences which reported on abductions of infants from separate maternity units within the UK.

Novice antenatal interviewees had differing views on the levels of security they expected upon arriving at their chosen maternity unit. Respondents residing in higher ACORN areas, having expressed concern about the media revelations, demonstrated empathy for the parents of the abducted child. These interviewees acknowledged that a security risk existed but were reassured by antenatal class referent groups and "common sense" that these incidents were isolated. Also, these women were able to describe additional security measures, afforded by the hospitals chosen for birth, to reassure patients.

Conversely, novice antenatal interviewees residing in lower ACORN areas demonstrated their concern with regard to "baby snatching" by use of body language and voice intonation. Concerns were illustrated with media examples. Respondents expected their own security and the security of their infants to be a priority and lack of resources or funding provided little comfort. Indeed these women expressed uneasiness at the apparent security inadequacies in all hospitals. The isolation of the "baby snatching" abductions did little to appease these respondents.

Postnatal Perceptions of Security

All novice interviewees, having returned home from the hospitals in which they gave birth, considered the security to be adequate. In an isolated incident, one interviewee expressed her concern over the lack of nursery facilities and considered this to be a failing in the security system. This reflected the view of the majority of focus group respondents during the initial exploratory stage.

5.5.2 Hospital Facilities

The definition of hospital facilities, for this research, is the equipment or service provision available to the users of the maternity wards during their hospital stay. Two facilities which arose during the focus group discussions were hospital food and cleanliness of the hospital toilets and bathrooms and these topics were raised during the antenatal and postnatal in-depth interviews.

The antenatal novice interviewees had taken significant measures already in preparation of attending the hospital. Respondents residing in higher ACORN residential groupings were considering taking cleaning fluids with them to the hospital, whilst interviewees residing in lower ACORN areas had already ensured food would be brought into the hospital for them during their postnatal stay.

5.5.3 Postnatal Perceptions of Hospital Food

Hospital food, by the nature of allocated resources, the homogeneity of the patients and various patient diets provides numerous difficulties for those whose task it is to produce meals for patients. However, **all** the novice interviewees maintained that the food was extremely disappointing even though during the antenatal interviews, these same respondents had indicated food was a low priority.

An explanation for this disappointment may begin by considering comparison norms for service quality. Parasuraman, Zeithaml & Berry (1994) identify two different comparison norms for service quality: desired service and adequate service. The first of these norms is the level of service a customer believes the organisation can and should deliver. The latter norm is the level of service the customer considers acceptable. Although Parasuraman, Zeithaml & Berry indicate that comparison norms and their interpretation has not yet been fully resolved, the "adequate" service expected by the novice respondents was not met. The disconfirmation, as a result of the failure to meet expectations, demonstrates that although the expectation of this particular service function was low, the requirement for it to be acceptable or adequate remained.

5.5.4 Cleanliness and Hygiene

Postnatal perceptions of cleanliness and hygiene were different depending on the hospital attended by the interviewees. The respondents were patients at either Category 2 or Category 3 hospitals (See Table **3.12**). That is, **there was no identifiable difference in perception between higher and lower ACORN** ***but*** *there was a difference in perception depending on the hospital used by the respondent.* The interviewees attending Category 3 hospitals indicated improvements could be made to ensure clean toilet and bathroom facilities. Category 2 hospital attendees made no such recommendations.

5.5.5 Ward Sizes

During the postnatal interviews, with the novice respondents, the issue of ward sizes was discussed. The interviewees either attended Category 2 or Category 3 hospitals, with Category 2 hospitals providing fewer beds per ward than Category 3 hospitals. Attending a Category 2 or Category 3 hospital was not directly related to the interviewee's residential grouping but could be attributed to the distance between the hospital and home of the interviewee. (See **5.3.1**)

Novice interviewees attending Category 2 hospitals with, typically, four beds to a ward were complimentary about this arrangement. The respondents described the smaller wards as having had a positive and familiar atmosphere. This may have been a result of the patients being "grouped" by the nursing staff as the respondents tended to share wards with patients from similar residential backgrounds and with patients who were of a similar age.

Novice interviewees utilising the facilities of Category 3 maternity units indicated the ward sizes were too large. Interviewee responses indicated smaller, enclosed wards would have afforded them the required privacy and quiet to both:

(a) become acquainted with their new infant

(b) recuperate from the fatigue of labour

Novices resident in both higher and lower ACORN areas preferred smaller ward sizes and considered larger wards to be inappropriate for recovery purposes.

5.5.6 Postnatal Length of Stay in Hospital

During the antenatal interviews, the novice respondents were asked if they had considered the likely duration of their postnatal stay in hospital. Interviewees residing in higher ACORN residential areas:

(a) Had no desire to leave hospital before the minimum or typical 5 day period

(b) Were prepared to stay in hospital as long as it was necessary to facilitate the transition from pregnancy to motherhood

These interviewees indicated they expected to feel slightly dazed and excited after the birth. As the majority of these respondents intended to try breast feeding, their desire to spend time in hospital was compounded by the expected difficulties associated with this feeding method.

The postnatal experiences of these interviewees reflected their initial expectations. As these respondents breast fed their children, they were grateful for the support they received during their postnatal stay.

The antenatal novice interviewees residing in lower ACORN residential areas indicated their desire to leave hospital as soon as possible after the birth of their infant. These respondents expressed a genuine dislike for hospitals, specifically citing the smell, other patients and the food as reasons for their reluctance to stay. Upon further questioning, the smell described by these interviewees, was representative of illness for them and added weight to their desire to leave hospital as soon as possible.

The postnatal experiences of the interviewees residing in lower ACORN residential areas were poor. The perceptions of these respondents were such that they felt patronised by the medical professionals and this added to their desire to leave hospital. An additional reason for leaving hospital at the earliest opportunity,

may have been the respondent's attitude towards other patients. The interviewees utilising Category 3 hospitals (See Table **3.12**) said that the patients, with whom they shared wards, were "not their type" or that the other patients were unconcerned with their dress conduct. This state of undress was typically a result of breast feeding. These incidences made the interviewees feel uncomfortable.

Novice respondents occupying lower ACORN residences, and using the maternity unit in the Category 2 hospital, were segregated on the basis of residential areas and age in the wards and, although these respondents were not overly critical of other patients or the medical professionals, they too left hospital as soon as possible. The general reason for this was attributable to an overall dislike of hospitals.

These postnatal respondents, resident in lower ACORN areas, spent between two and three days in hospital, with only one exception. This exception arose as the health of one respondent's child was questioned. This particular respondent said her highest priority was the health of her child, although she would have left hospital at an earlier stage had this been an option.

5.5.7 Perception of Postnatal Support

The novice interviewees, on the whole, gave birth in the early hours of the morning. As these interviewees had produced healthy children, their greatest expectation had been fulfilled. When the respondents arrived on the postnatal ward, from the labour suite, they were helped and supported into their hospital bed. These respondents also remembered having been shown the button to press to attract a nurse and were left to sleep.

However, respondents using Category 3 hospital facilities, were given no indication, even in daylight hours, where:

(a) the bathroom and toilet facilities were situated

(b) the nappies and fresh linen were kept

By observing other patients, the respondents were able to identify the sources of these facilities but the interviewees' expectations of guidance remained unfulfilled.

Differences in perception of postnatal support appeared to emanate from the feeding method chosen by the mother. The interviewees who chose to bottle feed their infants considered breast feeding mothers were given greater support by the nursing staff.

When questioned on postnatal availability of nursing staff, one postnatal novice respondent, resident in a higher ACORN area, said she initially breast fed her infant for the first two days after the birth. On the third day she felt uncomfortable, physically and emotionally, and decided to bottle feed her infant. She noted, however, that the nurses became considerably "cold" towards her as a result, inevitably upsetting the respondent concerned.

Clearly breast feeding mothers require additional support during the first days after birth, yet the respondents who chose to bottle feed felt the support given to the breast feeders was at the expense of their own needs and their expectations of support were not met.

5.6 EXPECTATIONS & PERCEPTIONS OF THE PATIENT'S CHARTER

One of the issues, concerning a hypothesis of this research, was to ascertain if the Patient's Charter had raised the expectations of the sample. The last question of the interview specifically asked the interviewees' perceptions of the Patient's Charter, and whether its existence had enhanced or changed the expectations of the respondents.

Interviewees residing in higher ACORN groupings described the Patient's Charter as a "customer service programme" which "made little difference" to their current expectations. Similarly they expected the Patient's Charter to make no difference to their perceptions or experience.

Novice antenatal interviewees residing in lower ACORN groupings declined to answer the question on the Patient's Charter or made "no comment".

This "no comment" response could largely be attributed to the contents of the Patient's Charter not being detailed or explained in the context of the question. Two reasons for this question design were as follows:

(a) The question would provide an indication of the percentage of participants, within the overall sample, familiar with the contents of the Patient's Charter

(b) The question would provide scope for the interviewees to disclose their perceptions of the Patient's Charter with no prompting from the question itself

The analysis, therefore, demonstrates less than half of the novice interviewees were familiar with the contents of the Patient's Charter and that those novice interviewees familiar with the contents did not consider their expectations to be raised by the existence of the Charter.

Postnatal Perceptions of the Patient's Charter

Whilst conducting the postnatal interviews, the question of the Patient's Charter, and whether its existence changed or enhanced expectations, was again raised. The novice interviewees' responded that they either still considered it to be a customer service programme or refused to pass comment. This demonstrated the experience of hospital and childbirth had not heightened the interviewees' knowledge of the Patient's Charter or altered their initial opinion.

It was considered appropriate, and suggested by senior members attending the European Marketing Academy Conference in May 1995, that the research should allow the interviewees the opportunity to respond to a similar question which outlined the contents of the Patient's Charter. This would allow the interviewees the opportunity to either remind themselves of the basic principles of the Charter or consider the information for the first time. In either instance, a greater depth of response was expected.

As a result of this advice, this question was built into the design of the quantitative questionnaire and is discussed during the analysis of the survey in Chapter Six.

5.7 EXPERT EXPECTATIONS & PERCEPTIONS OF THE ANTENATAL PERIOD

These expectations and perceptions of the expert respondents are discussed throughout the following sections and a summary of their responses is presented in Tables **5.5, 5.6** & **5.7**. These tables and analysis refer to expert respondents. That is, ***women who were interviewed during their second or subsequent pregnancies and interviewed again after the birth of their second or subsequent child.***

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
GPs to choose hospital for birth	Positive - often not the same hospital utilised for initial childbirth	GPs to choose hospital for birth	Service differences apparent between hospitals	+
Waiting for antenatal appointments	Considered waiting times to be extensive	Waiting for antenatal appointments	Considered waiting times to be extensive	+
Non-completion of birth plans and non attendance at antenatal classes	Less surprise at the unreliability of childbirth	Non-completion of birth plans and non attendance at antenatal classes	Less surprise at the unreliability of childbirth	+
Use of formal referent groups as a reliable source of information	Credible information given by medical professionals	Use of informal referent groups as a reliable source of information	Information given by family, friends and peer group most reliable	+
Literature used as a source of information	Useful reference tool for minor queries	Literature used infrequently if at all	Regarded as an additional option	+

Table 5.5: A Summary of Expert Interview Responses Relating to the Antenatal Period

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
The medical professionals would be experts in their field	Women gave the medical professionals responsibility for the birth	The medical professionals would be experts in their field	Respondents questioned expertise	Confirmation for residential group A but not for residential group B
Women had requested specific pain relieving drugs	Childbirth was a better experience than initial labour	Women had expectations of pain but not of specific pain relieving drugs	Pain relief that was accepted was taken on advice given by the medical professionals	+
Staff would be available throughout labour	Staff were continually present	Staff would be available throughout labour	Staff were continually present	Contradicted findings of the focus group
Role of the partner varied	Role of the partner varied	Role of the partner varied	Role of the partner varied	Contradicted findings of the focus group

Table 5.6: A Summary of Expert Interview Responses Relating to the Labour Period

Residential Group A	**Residential Group A**	**Residential Group B**	**Residential Group B**	***Initial Exploratory Research***
Expectations	**Perceptions**	**Expectations**	**Perceptions**	**Confirmation of Results**
Expected nursery and childcare limitations	Considered security to be adequate	Expected security to be a priority	Dependent on other patients to look after their children	+
Varied with different maternity units	Varied with different maternity units	Varied with different maternity units	Varied with different maternity units	Developed findings of focus group analysis
Food a low priority	Hospital food poor	Food a low priority	Hospital food poor	+
To leave hospital as soon as possible	Needed and received less support	To leave hospital as soon as possible	Perceived breast feeding mothers received more support	Developed findings of focus group analysis

Table 5.7: A Summary of Expert Interview Responses Relating to the Postnatal Period

5.7.1. Choice of Hospital

Invariably, the expert respondents residing in less well off and poorest council estates were returning to maternity units in which their existing children had been born. Responses, concerning repeat custom with previously utilised maternity units, indicated that the "choice" of hospital continued to be directly related to the distance the hospitals were from the houses of the respondents. These respondents commented that "being booked in" to the nearest maternity unit was a priority. Levels of service and previous experience of the same maternity unit appeared to be less important.

Expert respondents residing in the higher ACORN groupings displayed movement in housing area during their second or subsequent pregnancies. A change of property often denoted a change of maternity unit, reducing the opportunity for repeat custom. These expert respondents also indicated that they chose their maternity unit on the basis that it was the unit nearest their accommodation. As the maternity units were new to the respondents, previous experience was not a factor in the decision to commit to one particular hospital. Proximity then, is invariably more important than experience.

5.7.2 Length of Waiting Times for Antenatal Appointments

Expert respondents confirmed the analysis of the focus group findings, indicating that the waiting times for their hospital appointments were excessive. To exemplify their frustration, the respondents illustrated their hospital waiting times with examples of previous hospital attendance. The majority of experts attending hospital appointments were accompanied by their existing children. As these children would require both care and entertaining, the length of time the respondents were kept in the waiting room may have influenced their overall perception of the experience.

Contact time during hospital appointments was also raised. Although the expert respondents had often been kept waiting in the hospital waiting rooms, their expectations of a thorough examination were not to be fulfilled. The consultation period for these respondents was minimal. This confirmed the analysis of the focus group findings which also demonstrated minimal consultation and examination periods for the previous sample.

Higher and lower ACORN residents displayed *no difference* in perception for this aspect of their service.

This formal contact time with the medical professionals may have been more important to the expert respondents as their contact time with the medical professionals lessened considerably in comparison to their initial pregnancies.

5.7.3. Completion of Birth Plans

Expert antenatal interviewees, residing in higher ACORN groupings, commented that although they had previously completed a birth plan for their initial pregnancies, they would not complete a birth plan on this occasion. Collectively, the rationale for their responses were as follows:

(1) During a previous labour, the information recorded on the birth plan quickly became obsolete because of the unreliability of childbirth

(2) The disappointment, as a result of obsolete plans, was too great after meticulous completion and careful choice of options

(3) Respondents felt medical professionals did not entirely approve of their choices or their ability to choose

These expert respondents, resident in higher ACORN areas, indicated that their experience from their initial pregnancies substantially influenced their opinions and decisions during their second or subsequent pregnancies.

Expert respondents, resident in lower ACORN areas, indicated that during previous pregnancies they had not completed a birth plan and had no intention of completing a birth plan on this occasion. These respondents considered the birth plans to be "a waste of time" as childbirth was wholly unreliable.

5.7.4 Attendance of Antenatal Classes

Attendance of antenatal classes, which was an important source of information for novice interviewees resident in higher ACORN areas, was negligible for expert respondents within the same residential grouping. Although these experts utilised antenatal classes during their first pregnancies, the necessity for this type of information and support was deemed unnecessary for second or subsequent confinements by the interviewee respondents. Experts requested information directly from their formal sources of contact which included midwives, GPs and consultants. It is prudent to note, however, that the expert respondents utilising the maternity provision of smaller hospitals (See Table **3.12**) were aware of antenatal classes being unavailable or sporadic in their area.

Expert respondents, resident in lower ACORN areas confirmed their non attendance of antenatal classes during their pregnancies. This mirrored the results of the focus group analysis. Reasons given for not attending classes were lack of transport, lack of desire to do so and, after having had their first child, the lack of necessity.

5.7.5 Antenatal Referent Groups

The experience of the expert respondents can be viewed as twofold; primarily the experience will influence the expectations of the experts themselves and secondly the experts' experience will provide a fundamental source of information for novices generally.

Experts resident in higher ACORN areas were less likely, in comparison to lower ACORN residents, to draw on informal referent groups during the antenatal period. As such, the experience of expert respondents resident in higher ACORN areas was less likely to influence novices or other experts during the antenatal period. However, as expert respondents, residing in lower ACORN areas, provided informal information to novices and other experts, their experiences were far more likely to be influential as both novice and expert respondents resident in lower ACORN areas used informal referent groups throughout the maternity process.

5.7.6 Literature as a Source of Information

Expert respondents residing in higher ACORN areas indicated that their use of literature during the antenatal period was substantially less in comparison to their first pregnancies. These expert interviewees recalled seeking and receiving an overload of information during their initial pregnancies and felt additional information, in this form, was unnecessary for second or subsequent pregnancies.

Literature was discounted as a source of information for the expert respondents residing in lower ACORN areas. This finding confirmed the focus group analysis and further demonstrated the dependence the respondents, resident in lower ACORN areas, placed on informal referent groups.

5.8 EXPERT EXPECTATIONS & PERCEPTIONS OF THE LABOUR PERIOD

5.8.1 Medical Staff as Experts

Interview questions which focused on the expectations of intervention during labour, such as episiotomies or forceps, were met with positive responses from experts resident in higher ACORN areas. The findings illustrated both trust and respect for the medical professionals. Although these respondents wished to be consulted throughout the labour process, the analysis confirmed initial findings which positioned medical professionals as "experts". Postnatal interviewee responses indicated that attitudes towards the medical professionals remained the same.

Expert respondents residing in less well off and poorest council estates were the only category to question the expertise of the medical professionals. However, the expert respondents within this sample indicated that their experience of medical professionals had been unfavourable, which may have influenced their attitude. The basis for their remarks were grounded in the perceived sarcasm and patronising comments made to them during previous hospital visits. Postnatal interviewee responses indicated that these experts continued to have a negative opinion of the medical professionals.

5.8.2 Expectations & Perceptions of Pain Relief

As pain relief had previously been utilised by the expert respondents resident in higher ACORN areas, expectations were specifically centred on the variety of pain relief available. For these experts, the pain relieving methods chosen for their current pregnancy differed from that used during their initial childbirth. Specifically, these respondents were expecting to use fewer drugs during labour than they had before. Invariably, the postnatal responses illustrated the fulfilment

of these expectations as the expert respondents required fewer pain relieving drugs in comparison to their initial labours. Notably their labours were reduced in time also in comparison to their previous labours.

Interview respondents resident in lower ACORN areas appeared to have few expectations of the labour period. This was common in the focus group findings. The expert interviewees provided no indication of preferred pain relief or drug use during their forthcoming labour. Postnatal responses indicated the pain relief they accepted was taken on advice given by the medical professionals at the time.

5.8.3 Availability of Staff During the Labour Period

The initial empirical research suggested that focus group members were often left with their partners, but without the supervision or availability of the medical professionals, during the labour period. The in-depth interviews were used as a tool to measure the expectations of availability during labour and the perception of availability during labour. Both novice and expert interviewees indicated they had been supervised throughout their labour and had expected to have professional support on hand. This contrasted with focus group analysis.

It is possible that the focus group members in drawing their conclusions on availability of medical staff were affected by:

(a) peer pressure within the focus group

(b) staffing difficulties in the maternity unit at the time they gave birth

(c) not the availability of staff but by the *approachability* of staff

The first two reasons given are comprehensible, with the third argument offering a difference in perception. The importance of availability and approachability are

considered in the final stage of the empirical research by ranking the two in order of importance (See **6.4.2**)

5.8.4 Role of Partners

The expert respondents varied in their attitude towards the presence of their partner at the birth of their second or subsequent child.

The respondents were divided as to whether they:

(i) wished their partner to be with their other child or children

(ii) required their partner to play a supportive role in the labour suite

These differences in opinion could not be directly attributed to residential area. However, the respondents' attitudes may have been as a result of the availability of other family members to assume a parental role for existing children. This was not considered whilst the research was conducted, although could be an avenue for future research exploration in addition to the role of the partner.

5.9 EXPERT EXPECTATIONS & PERCEPTIONS OF THE POSTNATAL PERIOD

5.9.1 Expectations & Perceptions of Security

During the course of the antenatal interviews, the expert respondents raised the availability of hospital nurseries, indicating that during their previous hospital confinements they found it difficult to have a bath or a shower or even to leave the ward for a cigarette. Respondents resident in lower ACORN areas were dependent on other patients to look after their children whilst they left the ward for a bath or

a cigarette. Respondents resident in higher ACORN areas commented that they often felt obliged to wait until their visitors arrived so that their visitors could keep an eye on their infants. This confirmed the focus group findings.

During the postnatal interviews, respondents replied, when questioned about hospital security, that they felt their stay in hospital was too short to comment accurately on this aspect of service provision.

5.9.2 Hospital Facilities

Typically, expert respondents resident in the lower ACORN categories were returning to familiar obstetrics units. Their expectations reflected the facilities on offer during previous visits. Although their expectations of the bathrooms, nappy provision and catering were poor, their acceptance of the situation was apparent through their use of terminology and body language. Their postnatal perceptions indicated few facilities had changed since their last stay in hospital.

Conversely, the interviewees attending an unfamiliar maternity unit were considerably more positive about their future treatment. Notably, respondents attending unfamiliar maternity units were, on this occasion, utilising the services of *smaller* maternity units. The postnatal perceptions of these previously unfamiliar units were also favourable.

5.9.3 Perceptions of Hospital Food

The interviews were being used to confirm or discount the focus group analysis, and as such the interview format included questions on the expectations and perceptions of hospital food. As the focus group analysis highlighted the poor postnatal provision of food, which failed to meet the acceptable levels of service provision for novice and expert users, these findings were considered during the second empirical stage.

Notably *absent* during the expert antenatal and postnatal interviews were numerous complaints concerning postnatal sustenance. However, the length of postnatal stay in hospital experienced by the expert respondents was minimal. The opportunity to experience the hospital menu was therefore reduced and may account for the lack of concern about hospital food.

5.9.4 Cleanliness & Hygiene

The responses for questions relating specifically to expectations on cleanliness and hygiene were very similar to those given for hospital food. Expert interviewees returning to familiar obstetric units were accepting of the cleanliness and hygiene factors whilst expert interviewees going to a new maternity unit were more positive about the potential hospital provision. Experts resident in lower ACORN areas were less likely to question the level of cleanliness than those in higher ACORN areas. For residents in lower ACORN areas, the levels of satisfaction of the maternity units mirrored their initial expectations. Experts resident in higher ACORN areas were likely to expect an "acceptable" level of hygiene and varied on being satisfied and tolerating the facilities for the short period of time they were in hospital.

5.9.5 Ward Sizes

Experts using Category 1 and Category 2 hospitals (See Table **3.12**) commented that the wards in their chosen maternity units had a relaxed atmosphere and no more than four beds in any one ward. Experts, regardless of residential area, were positive about their postnatal stay in Category 1 & Category 2 hospitals. Interviewees utilising the service provision of Category 3 hospitals indicated that the number of beds per ward was too great to promote restful periods. As expert respondents typically had a shorter stay in hospital, the ward sizes were less of a

priority for them. However, the difference in perception between hospital Categories was noticeable.

5.9.6 Length of Stay in Hospital

As previously mentioned, the expert interviewees spent fewer days in hospital after their infants were born. The respondents resident in higher ACORN areas indicated their postnatal stay in hospital would be affected by a number of external factors:

(1) The expert respondents had at least one other child at home under the age of five

(2) Typically, the respondents were more comfortable with their new infant as a result of their previous experience

(3) The importance of bonding with the rest of the family was a priority

Not surprisingly then, during their postnatal interviews, these respondents commented that they returned home as soon after the birth as possible.

Expert respondents resident in lower ACORN areas expected, during their antenatal interviews, that their length of stay after childbirth would be minimal. The reasons given for this desire to return home were that they too had existing children at home and they had felt restricted during previous hospital confinements. These expert respondents also confirmed during the postnatal stage that they had returned home shortly after childbirth.

The findings on postnatal length of stay in hospital confirm the analysis of the focus groups.

5.9.7 Perceptions of Postnatal Stay

Expert respondents resident in lower ACORN areas expected breast feeding mothers to request and receive more attention than bottle feeding mothers. Numerous examples of incidents in which breast feeding mothers were given priority were provided by these respondents during their postnatal interviews.

Expert respondents resident in higher ACORN areas indicated that they needed less support during their postnatal period in hospital and as a result received less support.

5.10 EXPECTATIONS & PERCEPTIONS OF THE PATIENT'S CHARTER

One of the issues, concerning a hypothesis of this research, was to ascertain if the Patient's Charter had raised the expectations of the sample (See **5.6**).

Interviewees residing in higher ACORN areas described the impact the Patient's Charter had made on the NHS as:

"None that I can see really. I think it's all a bit of a PR job. I think there are very few people who will complain while they are there. It all sounds really good - although I don't know if I know enough about it."

(Expert Participant, Higher ACORN, PP2)

Similarly their postnatal interviews indicated that the Patient's Charter had made no difference to their perceptions or experience:

"I suppose I've seen notices up about how long you would have to wait and all. I get a barrage about it from my ex-consultant who says it's going to destroy the NHS and stuff, you know? I don't really have an opinion. It hasn't made any difference to my personal care at all."

(Expert Participant, Higher ACORN, PP1)

Expert respondents resident in lower ACORN areas, during the antenatal and postnatal interviews, declined to answer the question on the Patient's Charter or made "no comment".

Summary

This chapter identified the salient issues during, and as a result of, the in-depth interviews. Initially the antenatal and postnatal interviews of the novice respondents were considered, with the issues raised confirming or discounting the analysis from the first stage of empirical research. The second section of this chapter illustrated the views of the expert respondents which, similarly, were compared with the initial exploratory findings. Generally, the focus group findings were confirmed as a result of the analysis of the in-depth interviews. A matrix (**Diagram 5.8**), to highlight these results, demonstrates the characteristics of users' of the maternity services.

Novices(Higher ACORN)	Experts (Higher ACORN)
• Attend antenatal classes • Complete Birth Plans • Typically unfamiliar with hospitals • Use Formal Referent Groups • Postnatal Stay used for support • Use literature • Greater potential for repeat custom	• Typically attend antenatal classes during first pregnancy • Use both formal and informal referent groups • Shorter Postnatal stay through choice • Rely on previous experience
Novices (Lower ACORN)	**Experts (Lower ACORN)**
• **Unlikely to attend antenatal classes or to complete birth plans** • **Use Informal Referent Groups** • **Experience transportation difficulties** • **Would reduce postnatal stay if possible** • **Rely on previous experience of informal referent group** • **Greater potential for repeat custom**	• Unlikely to attend antenatal classes or to complete birth plans • Use Informal Referent Groups • Experience transportation difficulties • Shorter Postnatal stay through choice • Rely on previous experience

Diagram 5.8: Maternity User's Matrix – Key Characteristics

Distinct differences were identified between novice and expert respondents and between respondents residing in higher and lower ACORN areas. As the majority of issues raised during the first two stages of empirical research were consistent, the final piece of primary research, detailed in the following chapter, was designed to substantiate the data collated from the focus groups and in-depth interviews.

Four major hypotheses were developed using this analysis, and the major themes, from the first two stages of the research. **Table 6.2** demonstrates the link between the initial objectives, the key themes and the hypotheses.

The next chapter outlines the quantitative questionnaires, conducted in two maternity units in Edinburgh. This questionnaire then, was designed to confirm or discount hypotheses developed from the first two stages of empirical research.

CHAPTER SIX

6.1 INTRODUCTION

Chapter three discussed the methodology used for this third and final stage of empirical research. This primary research, providing the quantitative analysis, was to substantiate both the previous studies of focus groups and in-depth interviews and was to provide triangulation of data. A summary of the salient issues raised and the methodologies utilised during the antenatal, labour and postnatal periods of the respondents is presented in Table **6.1**.

Issues Raised & Discussed	Methodology used for specific topic
Choice of Hospital	Φ + *
Use of Referent Groups	Φ + *
Hospital Appointments	Φ + *
Length of Waiting Times	Φ + *
Use of Birth Plans	Φ +
Use of Literature	Φ + *
Antenatal Class Attendance	Φ + *
Expectations and Perceptions of Labour and Pain Relief	+
Expectations and Perceptions of Patient's Charter	+ *
Medical Staff as Experts	Φ +
Role of Partner	Φ +
Perceptions of Childbirth	Φ +
Hospital Facilities	Φ + *
Hospital Nursery Provision	Φ +
Security	Φ +
Length of Postnatal Stay	Φ +
Visiting Hours	Φ +
Postnatal Wards	Φ + *

Key:

Φ = Focus Groups
\+ = Interviews
* = Questionnaires

Table 6.1: Summary of Issues Raised and Methodologies Utilised During The Antenatal, Labour & Postnatal Period

Not all issues raised and discussed in the initial exploratory stages were tested in the final stage of research. This was as a result of the number of limitations of administering the questionnaire to the respondents, on a postnatal ward shortly after birth. Although the method of administering the questionnaire provided ease of access to a wide target group, the respondents would not have had a great deal of time to reflect on their overall service experience. As such, testing topics concerning the postnatal period were limited.

Additionally, questioning women on the satisfaction of their birth experience, given the short period of time between birth and the questionnaire responses, may have been biased as women, shortly after birth, tend to be very grateful that they have healthy babies (See **2.2.4.1**). Similarly, questions regarding the medical professionals and the role of the respondents' partners may not have provided reliable responses. This is recognised as a limitation of the overall research findings.

As the issues raised and discussed during the initial stages of empirical research were both extensive and comprehensive, and because the second stage of empirical research largely confirmed the initial findings, four major hypotheses were developed, with sixteen sub-hypotheses, which would be tested with a questionnaire based survey.

The questionnaire analysis is presented in four sections, with each of these sections considering a major hypothesis. Previous analysis chapters considered novice and expert women comparatively, with the antenatal period, labour stage and postnatal experience considered separately. As the major hypotheses consider four major issues, namely referent groups, effect of experience, residential location and guidelines for service provision, the questionnaire analysis will be presented under these headings with the categorisation of respondents and the elements of the maternity process duly considered within the text.

6.2 OVERVIEW OF QUESTIONNAIRE METHODOLOGY

The questionnaires were designed and used to establish the breadth and scope of the previous empirical findings, substantiating the analysis of the overall study. The questionnaires were self-administered by the author to a sample of 170 respondents on postnatal wards in two participating hospitals in Edinburgh. (For questionnaire see Appendix 4). This chapter concentrates on the results of the questionnaire and considers the issues pertinent to the research objectives. **Table 6.2** highlights the sampling of respondents selected for the three stages of empirical research.

Method	Total number of participants	Novice and Expert Categories	ACORN Categories (Higher and Lower)
Focus Groups	39	N = 18 E = 21	H = 23 L = 16
In-depth Interviews	12 x 2*	N = 6 E = 6	H = 7 L = 5
Questionnaires	170	N = 78 E = 92	H = 90 L = 80

* Interviewed before and after birth

Table 6.2: Summary of Respondents Selected During Empirical Research

Before recruiting potential respondents on the postnatal wards, the senior nursing staff were approached for information on potential respondents including parity (the number of children the women had) and their residential location (postcode).

Each questionnaire completion began with a brief resume of the study, and detailed the anonymity and confidentiality of the data, the independence of the study and ended with a request for information to complete the questionnaire.

Respondent comfort was also established at this stage. Feeding routine and general well being were considered before the questionnaire was completed. As the questionnaire pages were printed on only one side of A4, and with questions for novices and experts being visually separate, the overall process limited confusion and was completed in as short a time as possible.

The questionnaires were categorised by parity and residential area. This maintained the focus on the categories of novice and expert respondents as illustrated in chapter three (See **3.2.1**).

All questionnaire respondents had produced live children, although some of the women questioned had their children in the Special Care Baby Unit. This unit is designed for infants who are either prematurely born or have initial, minor difficulties. The respondents whose infants were in the SCBU were confident of the infants' development and continuing progression to full health.

The questionnaire analysis was conducted by considering frequencies, cross tabulations and Mann-Whitney tests. As Norusis (1993) recommends, cross tabulations of related variables should be obtained to identify anomalies. The non-parametric Mann-Whitney tests were appropriate to use as the objective was to test for a significant difference between two location statistics computed from independent samples (Daniel & Terrell, 1992).

6.3 DEVELOPMENT OF HYPOTHESES

In order to accomplish the initial objectives, and to ensure the study was cohesive, the analysis and presentation of the final stage of empirical research were considered with specific reference to the primary and enabling objectives (See **3.2.4**). **Table 6.3** identifies these specific objectives, the four major hypotheses and the salient issues raised throughout the empirical research.

Initial Objectives	Questionnaire Hypotheses (Developed from exploratory research)	Salient Issues Raised Throughout Empirical Research
• To identify expectations of users of the obstetric services	• Expert women will be more likely to have their expectations met as a result of their previous experience & will be more familiar with the hospital environment	• Effect of experience & parity
• To highlight issues concerning obstetric service users since Working for Patients (1991)	• A gap exists between the knowledge of the service provision and the guidelines provided by the Patient's Charter	• Guidelines for Service Provision
• To explore the use of formal and informal referent groups	• Novice women will have a greater dependency on formal referent groups with the opposite being true of expert women	• Referent Groups
• To ascertain if expectations are affected by experience and residential classification, using the variable parity	• Expectations and levels of satisfaction of the maternity provision will differ depending on the residential area of the respondent	• Residential Classification

Table 6.3: Objectives, Hypotheses and Salient Issues Raised Throughout the Empirical Research

As a result of the development of the major hypotheses, the questionnaire analysis not only substantiates or discounts the findings of the initial two stages but enables consideration of the application of the overall primary research study.

6.4 REFERENT GROUPS

The following major hypothesis was used to substantiate or discount the findings of the initial stages of primary research which, not only identified differences in attitude and perception to overall maternity provision by novice and expert respondents but, indicated a variance of dependency on both formal and informal referent groups. For the purpose of this questionnaire analysis, formal referent groups include: GPs, community midwives and antenatal classes. Informal referent groups for the purpose of this questionnaire analysis include: mothers, sisters and friends with children. Available literature was also considered as a source of information.

H (1) Novice women will have a greater dependency on formal referent groups with the opposite being true of expert women

(i) Novice women find formal referent groups more useful during their antenatal period

(ii) Expert women find informal referent groups more useful during their antenatal period

This hypothesis was tested by establishing the extent to which respondents found referent groups to be useful and if novice and expert respondents considered different referent groups to be more useful. The respondents interchangeable use of the terminology *usefulness*, *reliability*, *serviceability* and *dependability* was identified in the analysis of the in-depth interviews (See **5.3.5**). The choice for using the term *usefulness* as opposed to dependence was supported by the pilot group for the questionnaire. **Table 6.4** presents a summary of the statistical data for hypothesis **H (1)**. Full statistical data can be seen in **Appendices 5.1-5.11.**

Usefulness of information	Z	2 tailed p	Result
from mother	-1.3647	.1723	No significance
from sister	-2.6719	.0075	Significant
from community midwife	-.9953	.3196	No significance
from antenatal classes	-2.6846	.0073	Significant
from GP	-.1997	.8417	No significance
from friends with children	-.3960	.6921	No significance
from literature	-.3004	.7639	No significance

Table 6.4 Novice and Expert Use of Referent Groups and Literature

6.4.1 Informal Referent Groups

The Mann-Whitney test to establish the usefulness of information perceived to be given to novice and expert respondents by their mothers demonstrated no significant difference (p=.1723). Fifty four percent of expert questionnaire participants responded that the information they received from their mothers was very useful or useful with 47% of novice respondents expressing the same opinion. This Mann-Whitney test did not substantiate previous findings that novice respondents demonstrate less of a dependency on informal groups, with experts considering the experience of informal referent groups to be of greater value (See **Appendix 5.1**).

However, the Mann-Whitney test to establish the usefulness of information perceived to be given to novice and expert respondents by their sisters demonstrated a *significant* difference (p=.0075). 46% of expert questionnaire participants responded that the information they received from their sisters was very useful or useful with only 37% of novice respondents expressing the same opinion. This test substantiated previous findings that novice respondents demonstrate less of a dependency on informal groups, with experts considering the experience of informal referent groups to be more valuable. The focus group analysis raised the issue of experts sharing experiences with other experienced

mothers (See **4.3.2**). These experts would ask one another for reassurance or advice.

Although not all respondents had both a mother and a sister, all the respondents had at least one or the other family member with the majority having both. It was, therefore, considered appropriate to use these referent groups as examples of informal sources of information.

The final informal referent group considered, to establish the usefulness of information perceived to be given to novice and expert respondents, was friends with children. However, the Mann-Whitney test result provided no evidence to substantiate a significant difference between the two categories of novice and expert (p=.6921). 71% of expert questionnaire participants responded that the information they received from their friends with children was very useful or useful with 70.5% of novice respondents expressing the same opinion.

6.4.2 Formal Referent Groups

The Mann-Whitney tests were also used to identify if any significant difference existed between novice and expert respondents and their perceptions of the information they received from their formal referent groups. No significant differences were identified between the novices and experts perceptions' of usefulness of information from their community midwives or their GPs. However, the novices considered the information they received from antenatal classes to be significantly more useful ($p = .0073$) than experts. This supported the findings of the exploratory stages of research (See **4.6.4**) where novice participants believed, by attending antenatal classes, they were supported through their antenatal period.

The identical perception of the literature by both the novice and expert respondents may be as a result of this information not being susceptible to heterogeneity bias.

That is, as the literature for both categories of respondents is identical, then little, if any influence, can be exerted over the information.

(iii) Novice women are more concerned with the approachability of medical staff

(iv) Expert women are more concerned with the availability of medical staff

The initial empirical research indicated that whilst novices preferred the approachability of medical staff, experts demonstrated a preference for availability of medical staff. These third and fourth sub-hypotheses were tested using Mann Whitney t-tests with the results identifying no significant differences between novices and experts and their attitude towards the approachability (p=.3704) and availability (p=.4504) of medical staff. A very small difference appeared in the frequencies as 53% of novices ranked availability as very important and only 47% ranked approachability as very important. This does not support the findings of the first two stages of empirical research (See **Appendix 5.2**).

The lack of significance between novice and expert respondents and their perceptions may simply indicate that there is little to separate availability and approachability and that they are considered equally important by both categories.

(v) Novice women attend antenatal classes to make friends

Sixty three percent of novices attended antenatal classes, with 55% of them having attended antenatal classes for information. Twelve percent of novice respondents indicated that they attended antenatal classes to make friends.

This result completely contradicted the findings of the initial research and, as a result, this test discounts the exploratory research and the hypothesis is rejected.

The use of antenatal classes as a communication tool, however, would benefit from further research. Data which would provide reasons for non-attendance of antenatal classes, coupled with the advantages of attendance, may well provide a platform for an effective piece of communication to encourage attendance, promote knowledge and raise the profile of choice within the maternity provision.

Summary

The above data analysis considered and tested the hypothesis that novice women will have a greater dependency on formal referent groups with the opposite being true of expert women. This section focused on the salient issue of referent groups which was raised throughout the two previous stages of empirical research.

There is some evidence to substantiate the hypothesis, that novice respondents are more likely to consider formal referent groups to be of greater use during their antenatal period, whilst there is also some evidence to suggest experts consider informal referent groups to be more useful during the antenatal period. Research in this area may consider other sources of information or different categories of referent groups to test this hypothesis further.

An unexpected result, which did not support the existing collected data, was related to the topic of antenatal classes, where previously those who attended classes admitted doing so to make friends. In this instance, the questionnaire analysis provided strong evidence to suggest respondents attended antenatal classes for information. No significant difference between novice and expert respondents, and the usefulness of information they received from antenatal classes, existed. Further research into the area of antenatal class provision could be considered.

6.5 EXPERIENCE

The following major hypothesis was also used to further substantiate or discount the findings of the initial stages of primary research. During both the focus groups and the in-depth interviews, the data collated and analysed, indicated that experienced women were familiar with the overall process of maternity provision. As a result, they had more clearly defined expectations, built on previous experience(s).

H (2) Expert women will be more likely to have their expectations met as a result of their previous experience

(i) Experienced women are more familiar with the hospital environment

This sub-hypothesis was tested using both frequencies and Mann Whitney tests to compare the familiarity of the hospital environment between novice and expert respondents (See **Appendix 5.3**). The hospital environment was considered using the following areas of service provision: cleanliness, food, availability and location of nappies, availability and location of fresh linen, availability and location of bottled milk and, finally, availability and location of bathrooms and toilets.

Initially the questionnaire format allowed data to be collated from the entire sample of respondents, using a Likert Scale, on what their expectations were of the cleanliness of the hospital before arriving at the hospital in labour. The respondents were then asked to consider, using the same scale, what their level of satisfaction was, of the hospital cleanliness, as they were now using the postnatal ward. The questions were then repeated for the respondents' answers on expectations and perceptions of food.

It is acknowledged that the questionnaire only considers one level of expectation. Two levels of expectation were considered during the exploratory research (ideal and adequate) as the respondents were considering the process and outcome of service, typically associated with quality models (**2.5.2**). The timing of the

questionnaire, shortly after the birth, however, did not allow the respondents to answer questions on a global service experience. The respondents of the questionnaire were answering questions on antenatal and postnatal specific transactions. Satisfaction being transaction specific, as opposed to global, is typically cited as the difference between satisfaction and quality (Taylor, 1994 & Bitner & Hubbert, 1994). Further to this, as satisfaction has been considered to precede the perception of quality (See **2.5.2**) it was appropriate to use levels of satisfaction for these questions only.

Table 6.5 summarises the Mann-Whitney test results for **H(2)**. This hypothesis stated that experts would have their expectations met as a result of their previous experience.

Variable	Z	2 tailed p	Result
Expectation of Cleanliness	-1.2339	.2172	No significance
Level of Satisfaction	-.2640	.7918	No significance
Expectation of food	-.0626	.9501	No significance
Level of satisfaction	-1.3319	.1829	No significance

Table 6.5 Novice and Expert Expectations' and Perceived Levels of Satisfaction Concerning Tangible Aspects of Health Care

6.5.1 Cleanliness

Eighty nine percent of experts expected the hospital environment to be very clean or clean with 64% of experts having these expectations fulfilled. Eighty five percent of novices also expected the hospital environment to be very clean or clean with 62% of these novices having these expectations fulfilled. Clearly, there is a variance between expectations and levels of satisfaction of cleanliness which supports the findings of the initial focus group data on hospital cleanliness. The

hypothesis that experienced women will be more familiar with the hospital environment and, as a result, will have more developed expectations is not supported.

The reason for the percentage anomaly between expectations and levels of satisfaction may be that women with one or subsequent children do not always give birth in the same hospital. Indeed, anecdotal information from both the focus groups and the in-depth interviews suggested that often, during a second pregnancy, a bigger property was purchased to make room for the new infant. This may result in the "experience" of the women being particular to one hospital when they will actually experience a new environment.

The questionnaire format should have included a question on whether or not the experts had previously given birth in the same hospital. This is a limitation of the research and, as a result, further research in this area which allows for the inclusion of such data may or may not demonstrate a significant difference using a Mann-Whitney test.

6.5.2 Expectations and Perceptions of Food

72% of experts expected the food to be very poor or poor with 72% of experts expressing levels of dissatisfaction having experienced the food. Similarly 65% of novices expected the food be very poor or poor with 70% of novices expressing levels of dissatisfaction having experienced the food. Both novices and experts expected to be dissatisfied with the food and their dissatisfaction was evident from their responses.

As discussed in the literature chapter **(See 2.4)** if low expectations are met, satisfaction is not necessarily the outcome. The advantages of expecting poor quality food may allow the patient to make alternative arrangements, but the overall concept, that many facets of service make up the overall perception or

experience **(See 2.4),** suggests quality issues cannot be separated. Although one area of satisfaction may mask dissatisfaction in another area **(See 1.3)**, the service provider must not take for granted that the end-user will accept poor service provision in certain areas of health care.

Further analysis to test the hypothesis that expert women will be more likely to have their expectations met as a result of their previous experience was conducted and produced one significant result:

Variable	Z	2 tailed p	Result
Where nappies kept	-.4054	.6852	No significance
Where fresh linen kept	-.1237	.9015	No significance
Where bottled milk kept	-2.5893	.0096	Significant
Location of bathrooms and toilets	-1.0514	.2931	No significance

Table 6.6 Novice and Expert Familiarity with the Hospital Environment

6.5.3 Availability and Location of Nappies

Thirty six percent of novices were clearly informed regarding the location of the nappies on the postnatal ward. Although 53% of novices attended hospitals that did not provide nappies on the postnatal ward. Those novices who attended these hospitals had either been informed at their antenatal class, by their GP or by word-of-mouth that nappies were not provided during the postnatal stay. Similarly 50% of experts attended hospitals that did not provide nappies on the postnatal ward.

6.5.4 Fresh Linen

The information given to novices and experts regarding location of fresh linen demonstrated no significant difference between the two categories (p=.9015). 52% of experts were very clear or clear on the location of fresh linen with 49% of novices responding that they were very clear or clear on the location of fresh linen.

The lack of significance in the Mann-Whitney test does not support the hypotheses that experienced women are more familiar with the hospital environment (See **Appendix 5.4**).

6.5.5 Bottled Milk

A significant difference was demonstrated between novice and expert respondents and the perception of information they received about the location of bottled milk on the postnatal ward (p=.0096). 51% of novices were very well informed about the location of the bottled milk with only 44% of experts being very well informed on the same topic. Although this is a significant result, it does not support the hypothesis that experienced women are either more familiar with the hospital environment or that they are more likely to have their expectations developed and fulfilled as a result of their previous experience. Novices, in this instance, would appear to be more familiar with the hospital environment than experts.

As experts are less likely to spend a great deal of time in hospital after the birth of their second or subsequent child, it may be that they are less concerned with the availability and location of particular service items within the hospital environment.

6.5.6 Availability of Bathrooms and Toilets

No significant difference was demonstrated between novice and expert respondents and the perception of information they received about the availability and location of bathrooms and toilets on the postnatal ward.

There is no evidence to suggest that experts are familiar with the hospital environment as a result of their previous experience. The hypothesis is, therefore, rejected.

(ii) Experienced women know what to expect in terms of pain relief

(iii) Experienced women know what to expect in terms of available equipment

(iv) Experienced women know what to expect in terms of their own emotional behaviour

The above sub-hypotheses (ii-iv) were developed to establish if experienced women or, for the purpose of this research, "experts" considered their expectations to be more fully developed as a result of their previous experience. The questions from the survey on expectations of pain relief, expectations of available equipment and expectations of own emotional behaviour were only asked to the sample of expert respondents as they had previously experienced childbirth and the novices had not. The questions were asked to ascertain the level of experience the experts considered to have themselves as they were "repeating the purchase". The results were as follows:

- 76% of experts, when asked about their expectations of pain relief, were very clear that they knew what to ask for and what to expect
- 50% of experts, when asked about their expectations of available equipment, were very clear that they knew what to ask for and what to expect

- 43% of experts, when asked about their expectations of their own emotional behaviour, were very clear that they knew what to expect

It would appear from this collected data that the expert patient is very familiar with the type of drugs and pain relief available and is confident enough to request a specific type of pain relief. However, only half of the experts were familiar with the available equipment, with less than half confident in their expectations of their own emotional behaviour. This indicates that even experts are not confident or assured enough in their own expectations to comfortably predict their future experience.

It may be that experts become more familiar with the unreliability of childbirth or simply that they are less concerned with specific aspects of the service, namely available equipment, during their second or subsequent births.

As comparative data was not collated on novice expectations of pain relief, available equipment and emotional behaviour, significant differences between novices and experts cannot be measured. This is recognised as a limitation of the overall research.

Summary

The hypothesis that expert women will be more likely to have their expectations met as a result of their previous experience was not confirmed through the questionnaire data analysis. Indeed, the Mann-Whitney test results demonstrated that novice respondents were more familiar with the hospital environment. The hypothesis is, therefore, rejected. A possible explanation may be that the experts are spending less time in hospital after the birth of their second or subsequent child and are not required to be as familiar as novices with the hospital environment.

Finally, experts generally considered their previous experience with pain relief and drugs to be beneficial in developing expectations for future use. Only half of the expert respondents, however, considered that they knew what to expect in terms of available equipment with less than half being confident of their own emotional behaviour. As questions relating to these topic areas were only asked to expert respondents, comparative data with novice respondents was unavailable. This limits the potential significance of these results, with additional research into the intentional behaviour of novice and expert respondents being an option for further data collation and analysis.

6.6 RESIDENTIAL CLASSIFICATION

H (3) Expectations, referent groups and satisfaction levels of the maternity provision will differ depending on the residential area of the respondent

The above major hypothesis was used to substantiate or discount the findings of the two initial stages of primary research as the exploratory research indicated a variance in the information collated between respondents participating in the research from higher and lower ACORN residential areas.

(i) *Women resident in higher ACORN areas find formal referent groups more useful during their antenatal period*

(ii) *Women resident in lower ACORN areas find informal referent groups more useful during their antenatal period*

These two sub-hypotheses were tested using frequencies and Mann Whitney tests with the results identifying *significant* differences between the respondents resident in higher and lower ACORN areas and their use of information from informal and formal referent groups. For the purpose of this questionnaire analysis, as previously identified **(See 6.4)**, formal referent groups include: GPs, community midwives and antenatal classes. Informal referent groups for the purpose of this

questionnaire analysis include: mothers, sisters and friends with children. Available literature was also considered as a source of information. The results are presented in **Table 6.7.**

Usefulness of information	Z	2 tailed p	Result
from mother	-2.5385	.0111	Significant
from sister	-.6706	.5025	No significance
from community midwife	-1.9045	.0568*	Significant *
from antenatal classes	-5.4852	0000	Significant
from GP	-1.4228	.1548	No significance
from friends with children	-1.0588	.2897	No significance
from literature	-1.9964	.0459	Significant

(*If considered using the 1 tailed p: See results below)

Table 6.7 Higher and Lower ACORN Category Respondents' Use of Referent Groups and Literature

6.6.1 Informal Referent Groups

Thirty nine percent of questionnaire respondents residing in higher ACORN residential areas considered the information they received from their mothers to be very useful or useful, with 65% of questionnaire respondents residing in lower ACORN residential areas considering the information they received from their mothers to be very useful or useful (See **Appendix 5.5**). The Mann-Whitney test supports the findings of the focus groups and the in-depth interviews as respondents residing in lower ACORN areas were more likely to be dependent on informal referent groups (See **4.6.7** & **5.3.5**). The exploratory analysis detailed the participants use of informal referent groups to develop expectations of the maternity process.

Thirty four percent of respondents resident in higher ACORN areas found the information they received from their sister as very useful or useful with 50% of

respondents resident in lower ACORN areas finding the same. The hypothesis was not supported by the result of the Mann-Whitney test.

The final informal referent group, information from friends with children, demonstrated no significant difference between the respondents from higher and lower ACORN areas with 71% of respondents residing in higher and lower ACORN areas finding this information to be very useful or useful. This does not support the hypothesis that women in lower ACORN areas are likely to be more dependent on informal referent groups.

6.6.2 Formal Referent Groups

Fifty three percent of questionnaire respondents residing in higher ACORN residential areas considered the information they received from their antenatal classes to be very useful or useful, with 18% of questionnaire respondents residing in lower ACORN residential areas considering the information they received from antenatal classes to be very useful or useful (p=.0000).

This analysis supports the findings of the focus groups and the in-depth interviews as respondents residing in higher ACORN areas were more likely to be dependent on formal referent groups with the opposite being true of respondents residing in lower ACORN areas. Higher ACORN cite the information received from these sources as "credible" and "useful" (See **4.6.3 & 5.3.4**). The importance of this analysis is also demonstrated by the use of a Mann-Whitney test which indicates a significant difference between the respondents resident in higher and lower ACORN areas.

Sixty seven percent of questionnaire respondents residing in higher ACORN residential areas considered the information they received from the available literature to be very useful or useful, with 43% of questionnaire respondents residing in lower ACORN residential areas having the same opinion. Again, this

analysis supports the findings of the focus groups and the in-depth interviews as respondents residing in higher ACORN areas were more likely to be dependent on factual sources of information with respondents residing in lower ACORN areas preferring anecdotal information. Indeed, lower ACORN residents considered too much information may cause then to worry about what could go wrong, whilst higher ACORN residents continued to read information throughout their maternity process (See **4.6.6**).

A significant Mann-Whitney test result comparing respondents resident in higher and lower ACORN areas and the usefulness of information they received from their community midwife supports the hypothesis that women in higher ACORN categories are likely to be more dependent on formal referent groups. 63% of respondents resident in higher ACORN areas found the information they received from their community midwife as very useful or useful with 56% of respondents resident in lower ACORN areas finding the information they received from their community midwife as very useful or useful.

The Mann-Whitney test result (p=.0568) is a 2 tailed result. The objective was to test for a significant difference between two location statistics, computed from independent samples, with the hypothesis indicating one would be greater than the other. As such, a one tailed result could be applied. That is, the significance level could be allocated to one side of the distribution curve as opposed to split between the two. This result then supports the hypothesis that women resident in Higher ACORN areas are more likely to be dependent on formal referent groups.

There was no significant result comparing the usefulness of information received from GPs between respondents resident in higher and lower ACORN areas.

(iii) *Women resident in higher ACORN areas expected poor levels of cleanliness and were dissatisfied with regard to hospital cleanliness on postnatal wards with lower ACORN area residents having their expectations met satisfactorily*

This sub-hypothesis was tested using the same methods employed for the other major and sub-hypotheses. The Mann-Whitney tests identified no significant differences between the respondents resident in higher and lower ACORN areas in their expectations and perceptions of hospital cleanliness (p=.2030 & p=.8516 respectively). The hypothesis is, therefore, rejected. These results can been seen in **Table 6.8 & Appendix 5.6.**

Variable	Z	2 tailed p	Result
Expectation of Cleanliness	-1.2729	.2030	No significance
Level of Satisfaction	-.1871	.8516	No significance
Expectation of food	-.2.2790	.0227	Significant
Level of satisfaction	-.5049	.6136	No significance

Table 6.8 Higher and Lower ACORN Category Respondents' Expectations and Perceived Levels of Satisfaction Concerning Tangible Aspects of Health Care

The results for respondents resident in higher ACORN areas were similar as 90% of participants expected the hospitals to be very clean or clean, with only 68% having those expectations fulfilled. The anomaly between these results and the initial research are specifically related to the ACORN residential area responses rather than the issue of cleanliness. That is to say, a sample of focus group respondents, interviewees and questionnaire participants did not have their expectations met with regard to hospital cleanliness.

The results of this Mann-Whitney test discount the initial findings as the test did not show a significant result. The rejection of the hypothesis may be as a result of cleanliness and hygiene being heterogeneous in nature. Previous findings that identified differences in expectations and perceptions of cleanliness may not

necessarily have been dependent on the residential area of the respondent, but may simply have been individual responses which appeared to be collective.

(iv) *Women resident in higher ACORN areas were more familiar, than lower ACORN residents, with the hospital environment*

This sub-hypothesis was tested using the same methods employed for the other hypotheses. The results are manifest in **Table 6.9**.

Variable	Z	2 tailed p	Result
Where nappies kept	-.2404	.8100	No significance
Where fresh linen kept	-.7491	.4538	No significance
Where bottled milk kept	-3.2193	.0013	Significant
Location of bathrooms and toilets	-1.5415	.1232	No significance

Table 6.9 Higher and Lower ACORN Category Respondents' Familiarity with the Hospital Environment

The Mann-Whitney tests (See **Appendix 5.7**) identified no significant differences between the respondents resident in higher and lower ACORN areas with regard to the information they received on the location of nappies on the postnatal ward, information on where fresh linen was kept and information on where the bathrooms and toilets were located. A test to compare higher and lower ACORN residents with regard to information on where the bottled milk was located demonstrated a *significant* difference (p=.0013).

As a result of the focus groups and the in-depth interview analysis, it was expected that respondents to the questionnaire, resident in lower ACORN areas, would be less familiar with the hospital environment. This was established as the samples

used during the first two stages of research indicated that these respondents would be less likely to:

(a) Attend antenatal classes and therefore be unlikely to visit the hospital before giving birth

(b) Demonstrate familiarity with the hospital environment as they were likely to spend less time on the postnatal ward after giving birth than those respondents resident in higher ACORN areas

However, as the frequency results highlight in Table **6.10**, it is clear that respondents resident in lower ACORN areas were more familiar with the hospital environment.

ACORN Area	Hospital Facilities	Information	Frequency
Lower	Location of nappies	Very clear or clear	41% **NB: 51% of respondents provided own nappies**
Higher	Location of nappies	Very clear or clear	42% **NB: 50% of respondents provided own nappies**
Lower	Location of fresh linen	Very clear or clear	53%
Higher	Location of fresh linen	Very clear or clear	36%
Lower	Location of bottled milk	Very clear or clear **(*p=..0013)**	61% **NB: not all respondents bottle fed**
Higher	Location of bottled milk	Very clear or clear	36% **NB: not all respondents bottle fed**
Lower	Location of bathrooms and toilets	Very clear or clear	95%
Higher	Location of bathrooms and toilets	Very clear or clear	89%

Table 6.10: Questionnaire Responses Regarding Familiarity with Hospital Environment

This anomaly between the initial findings and the questionnaire discounts the exploratory research. The hypothesis that women resident in Higher ACORN areas would be more familiar with the hospital environment is rejected.

(v) *Women resident in higher and lower ACORN areas had their expectations met with regard to food on the postnatal ward*

This sub-hypothesis was tested using Mann-Whitney tests with the results identifying a *significant* difference between the respondents resident in higher and lower ACORN areas with regard to their expectations of food on the postnatal ward (p=.0227).

The frequencies indicate that both categories of respondents were equally disappointed with this element of service provision. Eleven percent of respondents residing in lower ACORN areas expected to be very satisfied or satisfied with the food, with 78% of the same respondents expecting the food to be very poor or poor. Nineteen percent of respondents residing in lower ACORN areas perceived the food to be very satisfactory or satisfactory with 73% of the same respondents perceiving the food to be very poor or poor.

Similarly, 6% of respondents residing in higher ACORN areas expected to be very satisfied or satisfied with the food, with 62% of the same respondents expecting the food to be very poor or poor. Nine percent of respondents residing in higher ACORN areas perceived the food to be very satisfactory or satisfactory with 70% of the same respondents perceiving the food to be very poor or poor.

Considering the overall result, the sub-hypothesis was substantiated, although the expectations were negative rather than positive. This issue is considered briefly in **6.5.2** but is more fully explored in **2.4**. In summary, the advantages of having poor expectations met for the end-user are minimal as alternative arrangements can and

have been made to bridge the expectation and satisfaction gap by preparing for service recovery. The disadvantages for the service provider may be far reaching as many facets of service make up the overall perception or experience.

Summary

The above section considered the third major hypothesis which was that expectations, referent groups, perceptions and levels of satisfaction of the maternity provision will differ depending on the residential area of the respondent. This was substantiated with significant test results for both informal and formal referent groups.

That is to say, respondents resident in lower ACORN areas were more dependent on informal referent groups (sisters) with respondents resident in higher ACORN areas demonstrating a greater dependency on formal referent groups (namely antenatal classes and community midwives). Available literature was also considered and significant results demonstrated that higher ACORN residents were more dependent on this as a source of information. The results for the use of other referent groups, such as friends with children, GPs and community midwives did not support the hypothesis.

The hypothesis that women in higher ACORN areas would be more familiar with the hospital environment was rejected.

Finally, both categories of respondents had their poor expectations of food met. The affect on overall perception of service provision for both categories of respondents may be affected by this facet of care and should be considered as an important area for development. The area of service recovery may need to be considered.

The following and final section considers the knowledge of the end-users and their familiarity with the guidelines of the Patient's Charter. This research was

conducted to establish if a gap existed between the knowledge of the service provision and the guidelines provided by the Patient's Charter to support the previous findings of empirical research.

6.7 GUIDELINES FOR SERVICE PROVISION

H (4) A gap exists between the knowledge of the service provision and the guidelines provided by the Patient's Charter

This hypothesis was used to substantiate or discount the findings of the qualitative empirical research which suggested that the Patient's Charter, and the guidelines for service provision which it outlines, has not been communicated effectively to those using health care provision.

The following sub-hypotheses were tested using cross tabulation technique to identify the significance between the responses of two separate questions (See **Appendices 5.8-5.10**).

(i) *There will be a correlation between women who know about the Patient's Charter and those who will be aware of GP surgery and hospital waiting times*

It was expected, as a result of the data collated from the initial stages of empirical research, that there would be an anomaly between those who were familiar with the most basic guidelines of the Patient's Charter and those who thought they were familiar with the Patient's Charter. In other words, although the respondents would have heard of the Patient's Charter, they would be unfamiliar with its contents.

As one of the most basic principles of the Patient's Charter is the guideline for expected waiting times for both GP surgery and hospital appointments, this area of the Charter, and the respondents' knowledge of it, was chosen to be tested. That is, patients were asked if there was a maximum waiting time before they were seen

at the GP surgery and hospital and were also asked if they were aware of the Patient's Charter.

6.7.1 GP Surgery Waiting Times

A cross tabulation demonstrated a *significant* difference between the responses when patients were asked if there was a maximum waiting time before they were seen at the GP surgery and if they were aware of the Patient's Charter (p=.00003). The results were as follows:

- 44% of questionnaire participants responded that they were unaware of maximum waiting times for GP surgery appointments and were also unaware of the Patient's Charter
- 35% of questionnaire participants responded that they were unaware of maximum waiting times for GP surgery appointments but that they were aware of the Patient's Charter
- 18% of questionnaire participants responded that they were aware of maximum waiting times for GP surgery appointments and that they were aware of the Patient's Charter
- 3% of questionnaire participants responded that they were aware of maximum waiting times for GP surgery appointments but that they were unaware of the Patient's Charter

These results fully support the findings of the focus groups and the in-depth interviews and are discussed (**6.7.2**) in conjunction with the results from a further cross tabulation on patient knowledge of maximum waiting times for hospital appointments and awareness of the Patient's Charter.

6.7.2 Hospital Appointment Waiting Times

A cross tabulation similarly demonstrated a *significant* difference between responses when patients were asked if there was a maximum waiting time before they were seen at the hospital and if they were aware of the Patient's Charter (p=.00352). The results were as follows:

- 36% of questionnaire participants responded that they were unaware of maximum waiting times for hospital appointments and were also unaware of the Patient's Charter
- 43% of questionnaire participants responded that they were unaware of maximum waiting times for hospital appointments but that they were aware of the Patient's Charter
- 20% of questionnaire participants responded that they were aware of maximum waiting times for hospital appointments and that they were aware of the Patient's Charter
- Less than 1% of questionnaire participants responded that they were aware of maximum waiting times for hospital appointments but that they were unaware of the Patient's Charter

These results fully support the findings of the focus groups and the in-depth interviews, demonstrating:

(a) A lack of consistent awareness of the Patient's Charter per se

(b) A lack of awareness of the most basic guiding principles of the Patient's Charter

(c) Confusion amongst respondents regarding awareness and knowledge of the Patient's Charter

At the outset of this research, it was considered whether this study should establish if the implementation of the guidelines of the Patient's Charter had raised the expectations of the end user (patient). Notwithstanding the methodological difficulties in identifying these expectations, the knowledge base of the sample of respondents, throughout the triangulation of data, appears so poor regarding the Charter itself, that the task would have been impossible.

The significance of the respondents being aware of the Patient's Charter, its guidelines and the overall effectiveness for service provision has been considered (See **1.1**).

Further analysis, to establish the existence of any differences in awareness and knowledge base between the end-user, was conducted on those who had been in hospital for any treatment over the last four years. This was to confirm or discount the following sub-hypothesis.

(ii) *There will be a correlation between women who have been in hospital within the last four years and those who say they are aware of the Patient's Charter*

Patients were asked if they had been in hospital over the last four years (since the implementation of the guidelines of the Patient's Charter) and were also asked if

they were aware of the Patient's Charter. It was expected that there would be a greater knowledge base amongst this sample. The cross tabulation, however, produced no evidence to support this (p=.06694) and the results were as follows:

- 16% of questionnaire participants indicated that they had been in hospital within the last four years and were aware of the Patient's Charter
- 7% of questionnaire participants indicated that they had been in hospital within the last four years and but were unaware of the Patient's Charter
- 39% of questionnaire participants indicated that they had not been in hospital within the last four years and were unaware of the Patient's Charter
- 38% of questionnaire participants indicated that they had not been in hospital within the last four years but were aware of the Patient's Charter

These results suggest that respondents who had been in hospital for treatment over the last four years, for any ailment, were less likely to consider themselves aware of the Patient's Charter.

On the whole, however, these results tend to support and substantiate the initial empirical research findings and this fourth major hypothesis. A lack of awareness of the Charter itself is evident in the above findings with no evidence from this research to indicate that the sample attending hospital for treatment, since the implementation of the Patient's Charter, had an increased level of knowledge of the guidelines or a greater awareness of the Charter itself.

From this third stage of empirical research, it is evident that a gap exists between the knowledge of the service provision and the guidelines provided by the Patient's Charter. The importance of effectively communicating the options and choices available within the health care provision and the extent to which patients should be aware of what to expect has been outlined extensively (See **1.1** and, for example: Appleby, 1996; Lowry, 1993; Jenkins, 1992; Steer, 1994 and Harrison,

Small & Baker, 1994). The gap in knowledge has to be addressed for the service provision to apply its professionalism and expertise effectively.

Summary

The questionnaire data analysis has provided *significant* results, demonstrating differences between:

(a) novice and expert respondents and their use of formal and informal referent groups with some evidence to support the initial findings and **H(1)** which was that novice women will have a greater dependency on formal referent groups (antenatal classes) with expert women depending more in informal referent groups (sisters)

(b) respondents resident in higher and lower ACORN areas and their use of both formal and informal referent groups, supporting the initial empirical findings and **H(3)** which was that expectations, referent groups and levels of satisfaction will differ depending on the residential area of the respondent

(c) respondents and their perception, awareness and knowledge of the Patient's Charter and its guidelines, supporting the initial empirical findings and **H(4)** which was that a gap exists between the knowledge of the service provision and the guidelines provided by the Patient's Charter

There was no evidence to suggest that expert women will be more likely to have their expectations met as a result of their previous experience **H(2)**. This hypothesis was rejected.

The following chapters detail the salient issues raised from both the primary and secondary research, with recommendations for future research and overall contribution to knowledge.

CHAPTER SEVEN

In this chapter, the key findings of the study will be explored. The discussion that follows centres on the research objectives and the salient issues raised during the empirical research. Whilst considering each research objective, the literature will be reviewed where appropriate.

7.1 CLARIFICATION OF THE LITERATURE

The literature suggested that patient satisfaction should be considered as a desired outcome of care. The way in which patients perceive or evaluate the service is essential for both monitoring and improving healthcare. Most studies to measure customer or patient perception of satisfaction use discrepancy theory and, although the performance of the service provider is high in credence (See **2.4.8.4**), these studies are patient based. Discrepancy theory identifies the difference between what the patient expects or desires and what the patient actually experiences.

The maternity provision is different to generic health care services as the service is typically provided over a nine month period. Patients have varying degrees of involvement and dependence during the antenatal stage, labour and the postnatal period. Such is the nature of service (See **2.4.8**) that each patient has different expectations and different perceptions of their experience.

It was envisaged that in order to achieve the main objective: ***to identify expectations of the users of the obstetric services and to consider if these expectations were affected by experience***, the changing nature of expectations and perceptions ought to be explored. As such, East's categorisations of novice

and expert user were employed (See **3.2.3**) and, as part of the qualitative research, the same interviewees were interviewed before and after the birth of their child. This was to ascertain any changes in expectation and perception over the period of the maternity process.

The empirical research identified expectations and perceptions of women who had used the maternity provision since the introduction of the Patient's Charter. The phases of the maternity provision were considered to be distinct by the participants and they could easily isolate incidents from the antenatal stage, labour or postnatal period.

The analysis of the primary research indicated that although some expectations and perceptions could be generalised this was not true of all issues raised. There was, however, a link between the expectations and perceptions of women from similar residential areas.

On the whole women wanted a live, healthy baby. This was a priority above all other issues and having this expectation fulfilled was the most important aspect of the maternity provision. Having delivered healthy babies, the women who participated in this study had varying expectations and perceptions of the service they experienced. In some cases, where the experience had perhaps not met initial expectations, the result of a healthy baby was used as a "trade off" in that the women felt this was of the greatest importance.

7.2 To highlight the issues concerning women who had used the obstetric services since the implementation of Working for Patients (1991)

The initial qualitative research established thirteen major themes (See **Table 4.1**) directly attributable to the three distinct stages of the maternity process. These thirteen themes can be adapted to form eight service related issues that the

participants of the focus groups and the in-depth interviews considered, in whole or in part, to contribute to:

(i) the developing of their expectations

(ii) the value of their experience

(iii) their future expectations

The service related issues that developed from the first stage of empirical research are: Choice, Control, Information, Access, Treatment, Security, Relationships and Environmental Aspects. These topics are familiar as quality variables and the dimensions of each issue typically has more than one element.

As the analysis focused on the categorisations of *novice* and *expert*, considering the influence of referent groups on decision making, this study was not designed to merely replicate previous service quality research but to develop an understanding of the constructs which shape women's expectations and opinions.

7.2.1 Choice

Women during the initial antenatal period were given the opportunity to decide the type of birth they were going to have, where they would deliver and, in some cases, the type of care they would prefer. The women in this sample were typical of the UK as a whole as they largely delivered in hospital. The majority of participants considered hospital to be "safe" and moreover, felt it was "normal" or "routine" to go to hospital.

The focus group and in-depth interview participants did not appear to exercise their right to choose which hospital in which they would give birth, despite the impetus on patient choice in the reform documents. The GP was typically expected to choose the appropriate hospital and /or the hospital nearest to the home of the participant.

The GP was also expected to advise on type of preferred care. This would, for example, be shared care with the hospital or Domicilary In and Out (DOMINO) where a team of midwives would ultimately be responsible for the delivery and care of the patient. There was little input from the participants on this topic as either they were unaware of the types of care available or the provision was not available in their area. A greater input of information and choice would perhaps encourage women to use their ability to choose.

7.2.2 Control

The opportunity to exercise both choice and control was offered to women in the form of a birth plan. Women were able to consider the type of drugs they wished to have during labour, the position(s) they wished to adopt during labour and people they wanted to be present at the birth. This document was typically completed by a very small sample of participants of the initial, exploratory research as the unreliability of childbirth, for most, was considered too great to try and structure with a birth plan.

As the emphasis is placed on *locus of control* (See **2.7.2**) this birth plan document, in its intention and design, would appear to be an excellent opportunity to afford women the choice and control they desire. However, the unreliability of childbirth and lack of motivation to structure labour ensured many participants of this qualitative research did not complete birth plans. Attitudes of medical professionals towards the use of the birth plan (See **5.3.3** & **5.3.4**) may also have led to less use of this communication tool.

7.2.3 Information

Information from the qualitative research was multi-dimensional and incorporated not only antenatal classes and current literature but informal and formal referent groups. It was clear from an early stage that women who attended antenatal

classes, read current literature and consulted both formal and informal referent groups (See **4.3.2**) resided in higher ACORN areas. Participants who were inclined not to attend antenatal classes, were unlikely to read extensively and largely consulted informal referent groups for advise and guidance with decision making resided in lower ACORN areas. The residential areas for these two groups of women were socio-economically diverse.

The lower ACORN area participants were not uncomfortable with their use of informal referent groups and trusted these informal sources implicitly. This initial finding was supported by both the in-depth interviews and, in part, through the questionnaire responses (See **6.6.1**).

The qualitative research also established that although some participants, resident in higher ACORN areas would attend antenatal classes, read extensively and consult with formal and informal referent groups, they were *still* surprised, after giving birth, at the unreliability of childbirth. The residents in lower ACORN areas, who largely consulted informal groups, did not attend classes or read a variety of literature were not surprised by their experience of childbirth.

7.2.4 Access

Qualitative research analysis considered both length of waiting times at the GP surgeries and antenatal hospital clinics. The waiting times for GP surgeries were, on the whole favourable, although there was no general consensus over the length of time spent waiting for antenatal hospital clinics. Women using the service for the first time (novices) considered their wait at the antenatal hospital clinics to be short, whilst women with children felt their waiting times to be longer.

Of more concern to all groups of women, during the exploratory research, was the length of time spent with each patient when the appointment was conducted. All women expected to have an opportunity to discuss their condition and ask

questions or ask for advice. It was deemed that the appointments were rushed and allowed inadequate time for questions or reassurance.

This highlights the issue of continuity of care and carer (See **2.7.2.1**) recently discussed at the Scottish Exhibition and Conference Centre (SECC), Glasgow in April 1999 at a Conference for Midwives. Participants of this research considered their antenatal appointments as key contact time to ask formal questions. As they were often consulting with a variety of medical professionals, the participants sought reassurance from a variety of individuals. As the appointments were typically short, the lack of continuity increased anxiety and reduced the opportunity for women to make informed choices.

7.2.5 Treatment

In addition to information, reassurance and continuity of care, the expectations and perceptions of the medical professionals were central to the overall experience of the women. The women unanimously trusted the midwives in comparison to other medical professionals, regardless of gender, and preferred receiving their care from midwives. Both the focus group and interview participants supported this analysis. This is consistent with the findings of the Policy Review Document (See **2.8**).

However the majority of women considered the medical professionals to be experts and positively abdicated the responsibility for their care to the medical professionals during labour. Indeed, the non-completion of birth plans was compounded by the expectations and perceptions of the medical professionals. The research participants felt that completing the birth plan may be inappropriate as the experts would know what action to take and what advice to give (See **4.4.2**).

7.2.6 Security

The focus group and interview participants indicated they were concerned with issues of security but, on the whole, appreciated that incidents of baby snatching were isolated. Those that attended antenatal classes were advised on preventative action.

However, the women considered a greater availability of nursery provision would alleviate the concerns raised by incidents of discrepancy in security. The women expected provision for their infants when they wanted to leave their postnatal hospital ward to go for a shower, to use the bathroom or go for a cigarette. They considered having to ask other patients or their visitors to watch their infants as inadequate. Leaving the baby unsupervised was thought to be wholly inappropriate.

7.2.7 Relationships

The role of the medical professionals and their relationships with the patient, other patients and one another was significant, to the overall perception of experience, for the research participants of the focus groups and in-depth interviews (See **4.8.4**). Similarly the relationship between the medical professionals and the partner of the patient was an important part of the service provision.

Generally the women perceived their relationships with the medical professionals to be acceptable, although there were exceptions to this. The majority of women positively commented on the relationship between the medical professionals and their partner although again, a small number of the patients perceived their partners to have felt uninvolved.

The greatest issue of concern regarding relationships were the perceptions of staff/other patient relationships and staff/staff relationships. The participants

considered incidents they witnessed between staff and other patients to be inappropriate. They commented that the staff had been insensitive and in some cases uncaring towards other patients. Similarly, the staff were observed to be critical of one another which the patients found unhelpful and unnerving.

As the restructuring and re-organisation of the of the NHS was to improve service quality, with service quality being the perception of the overall service, staff morale and motivation and relationships affect overall perceptions. Continuity of care may provide a greater depth of understanding of behaviour by patients and further research analysis may determine aspects of staff morale which could be addressed.

7.2.8 Environmental Aspects

The environmental issues that were raised focused on three aspects, that of ward sizes, visiting hours and facilities. If the participants used a high-technology, large hospital, they perceived their ward sizes to be too big. Participants using a less technological, smaller hospital considered the wards to be user friendly and more comfortable. This was raised during the focus groups and substantiated through the in-depth interviews.

Similarly the bigger hospitals were more limited in their ability to segregate patients. That is, smaller hospitals were able to put patients with similar ages, backgrounds and residential areas in the same ward. This was not experienced or possible in a large ward. Participants using high-technology hospitals expressed their desire for smaller wards. Those using hospitals with smaller wards were less affected by visiting hours. That is, other patients' visitors were less obtrusive in a smaller ward. Although a small aspect of care, a significant element of the overall perception of care.

However, both the qualitative and quantitative research indicated that expectations and levels of satisfaction of the maternity services could, in addition to the experience of the individual, be characterised by the residential area of the participant. The constructs shaping women's perceptions of the service provision appear to be somewhat related to the residential area they occupy as different ACORN residents use different sources of information.

7.3.1 Choice

Whilst highlighting the issues concerning women who had used the obstetric services, choice, as one of the key areas of the reforms, was raised as a topical issue. The majority of participants in the qualitative and quantitative sample either expected or preferred their GP to choose the hospital in which they would give birth. This was regardless of experience or residential area.

Despite the emphasis on choice, the variety of care, such as shared care or DOMINO (Domicilary In and Out), which should be available to women using the maternity provision as part of the implementation of the policy document (See **2.8**), were *infrequently* raised by the participants of the empirical research. Although a small number of women mentioned lack of availability of DOMINO (See **7.4.1**), the importance of choice, in these instances, was considered minimal by the participants.

7.3.2 Control

The greatest opportunity for structured or formal control during childbirth is the birth plan. As discussed, a women can use this document to choose her birthing companions as well as her birthing positions and types of pain relieving drugs. Women resident in higher ACORN areas were familiar with birth plans and, during a first pregnancy, were likely to have attempted to complete a birth plan - even if it

was not used during labour. Women resident in lower ACORN areas were unlikely to be familiar with a birth plan or its contents.

The informal referent groups of the women resident in lower ACORN areas gave advice regarding childbirth through the use of anecdotes. The informal referent groups of these research participants were always "experts" - that is mothers or grandmothers themselves. The participants in lower ACORN areas were prepared for the unreliability of childbirth and, as such, felt it unnecessary to try and control or structure their childbirth.

Women resident in higher ACORN areas had a greater opportunity to come into contact with formal referent groups as some members of their formal referent groups conducted the antenatal classes they attended during their first pregnancies. This resulted in women from higher ACORN areas having the opportunity to discuss control and their birth plan at length.

However, instances of the formal referent groups discounting the importance of the birth plan, and encouraging the women not to complete the plan as childbirth is unreliable, were observed. The importance and significance of the *locus of control* is questionable here and indicates further research into the area of control per se would be appropriate.

The use of informal groups by lower ACORN area residents is supported in the quantitative findings.

7.3.3 Information

Women occupying higher ACORN residential areas appeared to be more actively involved in their pregnancy and childbirth than women occupying lower ACORN residential areas. That is, women occupying higher ACORN residential areas were more likely to have attended antenatal classes during their first pregnancies, were

inclined to read a vast amount of literature on the topics of pregnancy and childbirth and were familiar with birth plans, the availability of pain relieving drugs and the side affects of pain relieving drugs used during childbirth. The opposite was true of women resident in lower ACORN areas. This was supported in the final stage of primary research.

Women resident in higher ACORN areas were more likely to ask for specific pain relieving drugs during childbirth and felt involved as a result of their knowledge.

Women resident in lower ACORN areas were familiar with the unreliability of childbirth and did not want to complete birth plans or structure their labour.

The most significant use of information for participants resident in lower ACORN areas was from informal referent groups. That is, women resident in lower ACORN areas were likely to consult and be influenced by their family, friends and peer groups as opposed to formal referent groups such as doctors, antenatal groups, community midwives or literature. These women trusted their informal referent groups implicitly. The issue of literacy was discussed (See **5.3.6**) and the opportunistic educating of women in areas of depravation was raised.

Women resident in higher ACORN areas received advice from both formal and informal sources but were more inclined to focus on advice from formal referent groups. This was substantiated using Mann Whitney tests to compare participants resident in higher and lower ACORN areas and the perceived usefulness of the information they received from antenatal classes and the community midwife.

7.3.4 Access

The maternity process was familiar to all the research participants and this facilitated ease of data collation and allowed an understanding to develop of the issues which were significant or important to women using the maternity services.

Not all aspects of the maternity process were experienced by the research participants though, for example, not all women had the necessity for forceps or an episiotomy.

One aspect of service provision, only experienced by research participants resident in lower ACORN areas, was significant to their overall service experience. The perceived lack of a transportation facility during labour, raised during the focus groups, was considered by the women resident in lower ACORN areas to be a key factor in determining overall provision of care. These women felt concerned that they were expected to make their own way to the hospital whilst they were in labour, even though the majority did not have access to a private car.

As routine labour is not considered to be an emergency, pregnant women during the antenatal period are encouraged to prepare for making their own way to hospital at the onset of labour. The Ambulance Services, and their emphasis on emergency patients (See **4.7.3**), was discussed and the cases of emergency during labour were considered. As communication between formal referent groups and participants in lower ACORN areas was identified throughout the three stages of primary research as weak, a better level of communication between these groups may have allowed greater preparation for this element of the maternity process.

The constructs then, which shape women's expectations and perceptions are not only related to formal or informal referent groups or the heterogeneity of the individual but to the social environment in which the women resides.

7.3.5 Treatment

The inability to question or contribute to the technical aspects of care is known as credence (See **2.4.8.4**) and this could be a key factor in the abdication of responsibility for care to the medical professionals by this research sample. The women during the qualitative research, regardless of experience or residential area,

clearly felt that the medical professionals were experienced in their specialist field and were capable of deciding what was best for the mother and baby.

7.2.6 Security

The time at which the consumer chooses to use the service may be critical to the performance of the service, and, subsequently the overall evaluation of the service experience. As the women discussed security shortly after a number of abductions from baby units, it may be that their awareness of security issues were heightened and that security would have been less of an issue if the qualitative research had been conducted before the abductions had taken place. Factors external to the situation can also shape expectations and perceptions.

7.2.7 Relationships

The women who perceived their relationships with the medical professionals to be poor, resided in lower ACORN areas and these women were also likely to spend less time in hospital on a postnatal ward. These women, during the focus groups and the interviews, suggested the attitude of the medical professionals was condescending, although this was not given as a reason for leaving hospital at the earliest opportunity.

Each service encounter will be different as services are delivered and consumed by individuals. Yet the extent to which these women *expected* this approach from the medical professionals, as a result of the experience of their informal referent groups, was not fully explored.

As the perception of an overall experience has been observed as the "normalising" of the situation it may be that these participants perceived the medical professionals' attitude after normalising the service exchange with informal referent groups.

That is, if the informal referent groups are, as this research suggests, significant as a source of information and advice, it would be useful to consider not only the influence of the informal referent groups and their previous experiences but the relationship between the perception of the staff/patient relationship, the normalisation of an individual experience and the influence of the informal referent groups.

7.3.8 Environmental Aspects

The constructs shaping women's expectations and perceptions of tangible aspects of the maternity provision were, for some research participants, characterised by their residential area. Women residing in lower ACORN areas generally disliked hospitals and cited the food, the "hospital" smell, the routine and the constant monitoring as indicators of dissatisfaction. These women tended to leave hospital at the earliest opportunity although the questionnaire analysis indicated that they were more familiar with the hospital environment than the women residing in higher ACORN areas.

7.3.9 Summary

Formal and informal referent groups are used with varying intensity. Women residing in higher ACORN areas are likely to focus on formal referent groups with the women residing in lower ACORN areas accessing information from informal groups. The constructs that shape women's expectations and levels of satisfaction of the obstetric services are widespread and include their social environment in addition to uncontrollable external factors; such as the time at which the service is used.

This research has fulfilled the objective of exploring the use of formal and informal referent groups, whilst developing an understanding of the constructs which shape women's expectations and perceptions of the obstetric services.

7.4 TO ASCERTAIN IF EXPECTATIONS ARE AFFECTED BY EXPERIENCE, USING THE VARIABLE PARITY

In a consumer behaviour scenario, there will be users of the product or service who are more experienced than other users. That is, there will be "experts" who will be familiar with the benefits and disadvantages of the product or service. "Novices", conversely, will be unfamiliar with the product or service although may have sought additional information before placing themselves in a buying situation.

East (1992) identified these types of buyers and used these categories to test his original hypotheses (See **3.2.3**). These hypotheses focused on the extent to which novices and experts used referent groups in aiding their purchasing decisions. His research analysis contradicted his initial hypotheses indicating that novices are less likely to consult referent groups with the opposite being true of experts in a buying situation.

Within the maternity provision, there are women who are using the service for the first time (novices) and women who are using the service for the second or subsequent time (experts). East considered novices and experts in the context of product purchase (See **2.6.2.1**) where this research considers novices and experts in a service context.

This research used East's categorisations to determine if novices utilise the support of referent groups to a greater extent than experts and to establish if, as a result of varying experience, expectations and levels of satisfaction, perceptions and use of referent groups also differed.

This chapter has already established a link between women residing in similar residential areas with similar expectations and levels of satisfaction of the maternity services. This section focuses on the categorisations of novice and expert users, their expectations and levels of satisfaction and perceptions of the maternity services, whilst considering the influence of experience and/or referent groups.

7.4.1 Choice

The importance of choice was not apparent during this empirical research. The availability of types of care open to women such as a home birth, shared care (GP and hospital treatment) or DOMINO birth (Domiciliary In and Out) where care is provided by a team of midwives, was not identified as a significant issue by the research participants. A small number indicated that DOMINO births were not available in their region, although their concern over this lack of availability was minimal.

DOMINO births, and the possibilities of home birth, were discussed largely by the "experts" or experienced mothers residing in higher ACORN areas during the focus groups and interviews. Novices residing in higher ACORN areas were familiar with the types of treatment available but perceived that because they were first time mothers, and this was supported by their formal referent groups, their only choice was a hospital delivery. This was as a result of their unknown risk factor during labour. That is, labours typically follow a pattern, and difficult first labours can establish problems for future labours. As such, novices perceived they were "expected" to have their first child in hospital although they indicated that they would expect greater choice during subsequent pregnancies.

Novices and experts residing in lower ACORN areas attended hospital for delivery and were either unfamiliar with the alternatives or did not articulate their preferred option.

7.4.2 Control

Experts, being more familiar with labour than novices, were available to verbally indicate preferences for labour such as preferred type of drug or preferred type of birthing position. As such, experience would appear to have a direct causal link to expectations. The formal structuring of labour by the use of a birth plan was an opportunity taken by very few of the research participants but those who formally recorded their preferences were identified, during the qualitative research, as novice participants resident in higher ACORN areas.

This could be attributed to novice participants resident in higher ACORN areas attending antenatal classes and being more familiar with the availability of options. Expectations, in this instance could be influenced, indirectly through sources of information.

The completing of a birth plan during the antenatal period then, was sporadic and typically not followed during labour for (a) medical reasons, or (b) merely as a result of the unreliability of childbirth. This was raised during the focus groups and in-depth interviews. The concept of control and women's desire to control their childbirth is not without evidence (See **2.7.2**), but does not manifest itself in the use of these formal documents. Further research may indicate a greater depth of analysis of the completion or non-completion of birth plans. However, if the expectations of the users are not documented, providing individual care becomes rather haphazard.

7.4.3 Information

Novice respondents demonstrated less of a dependency on informal referent groups, with experts considering the experience of informal referent groups to be of value. This finding was significant and supported by the quantitative analysis.

This is concurrent with East's findings on novice use of referent groups. Significant results were identified in the final stage of empirical research for the dependency of novices on formal referent groups. The qualitative research also identified this category as more likely to (a) seek out additional information and (b) attend antenatal classes.

Novices residing in lower ACORN areas, during the qualitative research, were observed to be dependent on informal referent groups. This provided a significant result in the questionnaire analysis (dependence on mother), and indicated that novices residing in lower ACORN areas were more dependent on informal referent groups than novices residing in higher ACORN areas.

During the qualitative research, those that attended antenatal classes indicated that they did so primarily to make friends. Those that attended antenatal classes were identified typically as novices. However, the questionnaire findings contradicted this, suggesting the primary reason for antenatal class attendance was for information.

The communicating between service provider and user during antenatal appointments, during antenatal classes, through the birth plan and through the use of literature enhances the overall process for both parties if the communication is effective. If, however, as this qualitative research indicates, antenatal appointments are rushed, antenatal classes are attended by a selection of novices, the birth plan is sporadically completed and the literature is used extensively by higher ACORN residents only, the communication between service provider and user could be substantially improved.

7.4.4 Access

Both expert and novice participants, during the qualitative research, perceived the antenatal appointments to be too time constrained, allowing inadequate time to ask

questions or seek reassurance. However, the novice participants perceived the waiting time for the antenatal appointments to be very short whilst the experts considered it to be too long.

This difference may have occurred as a result of various hospital and various GP policies or could have occurred as the experts were more conscious of the time. That is, as experts were likely to have young children with them or being looked after elsewhere, the waiting time may have been perceived to be longer. Experts would previously been attending the hospital during their first pregnancy as a novice. The previous experience of the experts then, would perhaps influence expectation and perception of waiting times, if waiting times had previously been considered short.

7.4.5 Treatment

Women who were defined as experts in this research based their expectations of childbirth, treatment and a hospital delivery on their previous experience(s). They also compared the perceptions of their most recent service experience to previous experience(s). Experts described themselves as being more confident during the second and subsequent experiences although they still implicitly trusted the medical professionals and had high expectations of a healthy baby.

Experts considered themselves to be able to contribute more to the service exchange as they were familiar the terminology and experience of labour itself. However, there was no evidence to suggest that experts were more familiar with the hospital environment as a result of their experience (See **6.5**). According to the qualitative analysis, experts' experience during childbirth particularly was enhanced during second and subsequent pregnancies as their deliveries were easier than they either expected or remembered.

7.4.6 Security

Expectations and perceptions of security, raised and discussed during the focus groups and in-depth interviews, varied for novices and experts and this could largely be attributed to the length of postnatal hospital stay the novices and experts experienced. Typically, the experts left hospital as quickly as possible to return to the family home and look after their other child (ren). As they expected to spend a short period of time in hospital they considered security to be important but not their top priority. Experts indicated they were more concerned about the issue of security before they had their first children.

Novices, conversely, were concerned with issues of security and considered additional nursery provision to allow patients to leave their infants to go for a shower or a cigarette would be appropriate.

7.4.7 Relationships

During the initial stages of the empirical research, the participants indicated that the perception of the relationship they had with the medical professionals was affected, not only by the one to one interaction they experienced in the service exchange, but in the perception of the behaviour and attitudes the medical professionals had towards other patients (See **4.8.4**).

The perception of attitude and behaviour towards patients by staff was not specifically attributable to novices or experts. However, experts indicated that they knew what to expect of medical professionals in the one to one aspect of care because of their previous experience. Novices were unsure of what to expect in terms of relationships with medical professionals because they had not previously delivered a baby and their previous experience of a hospital environment was typically when they were children themselves.

An issue centring on staff /patient relationships, which was raised during the qualitative research, was the approachability of medical professionals and the importance of this in the overall perception of the service experience. During the focus groups and in-depth interviews, the novices suggested that they felt some members of staff were more approachable than others. Experts considered themselves to be more confident during second or subsequent pregnancies and labour. They were more concerned about the lack of staff availability rather than the approachability of those available for postnatal support.

Novices then, appeared to be more concerned with the approachability of staff, whereas experts were more concerned with the availability of staff. However, this information was not substantiated with the questionnaire analysis. Simply, the lack of substantiation may simply suggest availability and approachability are equally important for staff/patient relationships.

7.4.8 Environmental Aspects

Having conducted the initial qualitative research, the data indicated that experts, as a result of their previous experience, would be familiar with pain relief, available equipment and would know what to expect in terms of their own emotional behaviour.

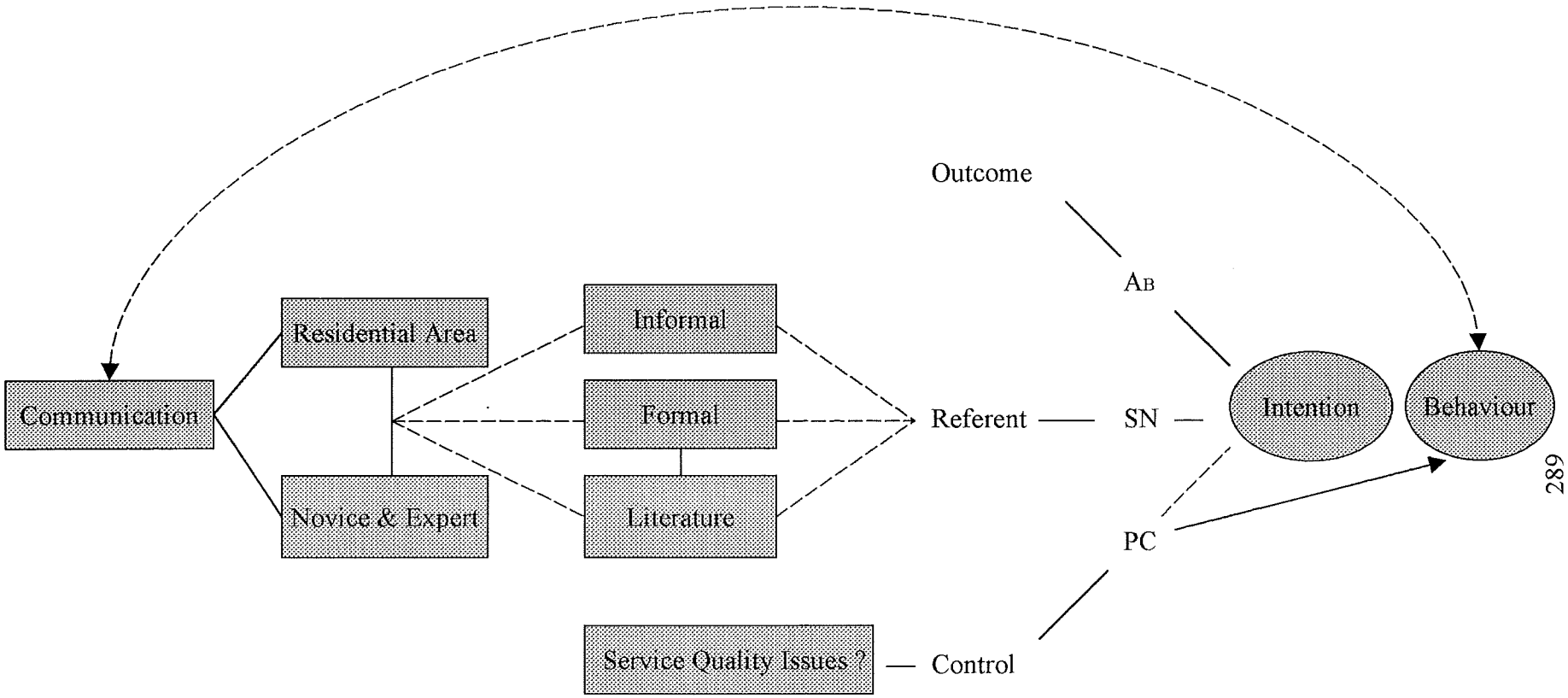
Although experts were more familiar with aspects of their care, as a result of their previous experience, significantly, less than half knew what to expect in terms of their emotional behaviour. The environmental aspects were less important than the support they received during the initial postnatal period.

Novices were concerned with the environmental aspects of the hospital and requested families and friends to bring food with them into the hospital. This

category also expected, and were prepared, to clean out bathroom facilities before using them.

7.5 LOCATION & REFERENT GROUP AFFECTS ON THE THEORY OF PLANNED BEHAVIOUR

Considering the Framework Model (**Model 3.1**) and the results of the final stage of empirical research, **Model 7.1** demonstrates the significance of the research in relation to Ajzen's existing model of Planned Behaviour (1985) and East's categorisations of novice and expert (1992).



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Model 7.1: Location & Referent Group Affects On The Theory Of Planned Behaviour

This model adds to existing knowledge in this area as it identifies three sources of information, which include *formal referent groups*, *informal referent groups* and *literature*. Previously *types* of referent groups have not been categorised. These referent groups are used differently by residents in varying ACORN groupings. That is, lower ACORN residents use informal referent groups to a greater extent than higher ACORN residents. Conversely, higher ACORN groups use formal referent groups and literature to a greater extent than lower ACORN residents. Novices resident in higher ACORN areas use formal referent groups and literature to a greater extent than any other category.

This model is significant as it considers communication and the three sources of information. If communication can be used to enhance or manage the service experience, as suggested by Zeithaml (1991), this model indicates that by communicating to novices and experts through the referent groups they currently use, including the use of residential area, the service experience could be better managed to include repeat purchase, word of mouth, service recovery and monitoring and evaluating behaviour.

Further to this, the model also suggests considering service quality issues in relation to control and perceived control. If, for example a woman believes she has access to a home birth (perceived control) is she more likely to have one? This area was not considered in any depth in this research but could be considered in further research. The contribution of this model is the use of referent groups in terms of communication.

7.6 THE PATIENT'S CHARTER

Expectations and the factors affecting their development was central to this study. The literature review raised questions and concerns over the implementation of the Patient's Charter suggesting patients' expectations would be raised, although a number of the service providers considered this to be unrealistic. This research

sought to determine what users' expectations were, how they were influenced and if these expectations had been raised by the implementation of the Patient's Charter.

The majority of respondents were not familiar with the Patient's Charter, and those who were familiar with particular elements of the charter considered its implementation to be no more than a public relations exercise or an attempt at a customer service programme. The service users' unfamiliarity with the Patient's Charter was substantiated with significant results in the questionnaire analysis ($p=.00003$ & $p=.00352$). The expectations of these research respondents were not consciously raised by the implementation of the Patient's Charter (See **5.10**).

7.6.1 Summary

For each phase of the service there were similar expectations, levels of satisfaction and perceptions raised by all research participants. This indicated a common degree of understanding and facilitated the initial qualitative research. When there were differences, mainly between novices and experts, they reflected a wide range of service aspects, as well as use of formal and informal referent groups. Some differences were related to information and some to environmental aspects. Whilst the literature would suggest choice was paramount for service users, the women in this research indicated their desire for reassurance and empathy as opposed to taking control.

Concerns raised in the literature by the service providers, that expectations have been raised as a result of the implementation of the Patient's Charter, are not supported within the context of this research.

This study has addressed the research objective of identifying expectations and perceptions of service users whilst considering the variable of experience.

7.7 CONCLUSION

This chapter has presented a discussion of the main findings of the qualitative and quantitative results of the study. The depth and breadth of data generated by triangulation of data was extensive, and only the key issues are manifest in this thesis. This discussion has focused on the key findings of the study in the context of the objectives and concludes that they have been addressed in the research.

CHAPTER EIGHT

This chapter considers the overall study and focuses on three areas: the main issues in the literature, the limitations of the study and, finally, the contribution to knowledge and future direction for research.

8.1 MAIN ISSUES IN THE LITERATURE

8.1.1 The Research in Context

During the initial stages of the research, the provision of the maternity services was studied within the context of the National Health Service. As the NHS has gone through a period of re-structuring, the management of this process, and the internal and external influence of this change on service provision, has been of growing interest to academics, practitioners and service users (Stevenson, Marshall & Javalgi, 1995). The necessity to focus on the views of the service users' in this relatively unstable environment was not only grounded in Working for Patients (1991) but in the Audit Commission's First Class Delivery: Improving Maternity Services in England and Wales (1997) and policy initiatives in Scotland (see CRAG/SCOTMEG, 1995).

Within the maternity provision, the development of guidelines, resulting from the policy review document for Maternity Provision in Scotland (1993) and Changing Childbirth in England and Wales (1993) clearly focused on consumer orientation. The maternity provision continues to differ from general health care practice as, unless pregnant women are having a difficult pregnancy, the pregnancy should be considered as a healthy event. Although the improvements in the delivery and quality of the maternity services has been widespread (Thomas et al, 1998), the

rhetoric and implementation of quality improvements continues to be questioned (Wilcock, 1998).

The impending introduction into Parliament of a Health Services Bill (Dimond, 1999) designed to implement A First Class Service: Quality in the new NHS (Department of Health, 1998) has major implications for purchasers and providers as pregnant women would be able to point to standards which they could expect to see provided in maternity services.

8.1.2 Expectations and Perceptions

Dion, Javalgi & Dilorenzo-Aiss (1998) evaluate the service expectations model developed by Zeithaml, Berry and Parasuraman (1993) and their results indicate that individuals perceive two distinct standards of service (adequate and desired) but that a range of acceptable values were apparent. Those who had a greater zone of tolerance had a more favourable view of service quality. These findings were concurrent with the findings of this research on expectations.

Similarly, this research demonstrated, through the exploration and identification of formal and informal referent groups, that novice individuals appear to set their expectations in line with what they have been promised. This was substantiated by the findings of Dion, Javalgi & Dilorenzo-Aiss (1998).

Bagozzi and Li (1988) had their research confirmed by the same authors as both studies demonstrated that individuals could be expected to temper their ideal service level as a result of previous experience. This thesis also identified expert users as using their previous experience to develop future expectations.

8.1.3 Experience

Parasuraman, Berry & Zeithaml (1991) observed that if the consumer was more experienced, their expectations of the service were likely to be higher and they were more likely to voice their opinion. This was because they knew what to expect as a result of previous experience. East (1992) found experienced consumers (experts) more likely to be dependent on referent groups with inexperienced consumers more interested in the benefits of the product or service.

This research indicated that experts considered themselves more confident because of their previous experience but did not necessary demand more than inexperienced consumers. This research demonstrated that experts are not more likely to be familiar with the hospital environment as a result of their previous experience. Qualitative research indicated experience impacted on expectations in terms of confidence with medical professionals and choice of pain relief.

Experts were more dependent on informal referent groups although novices quite clearly demonstrated a dependence on formal referent groups - particularly during the antenatal stage. The previous literature on experience then, was useful in providing categories of groups on which this research could build but the results obtained by previous researchers did not incorporate types of referent group and did not consider socio-economic groupings. This research also found novices used referent groups rather than benefit beliefs on the outcome of the product or service.

8.2 RESEARCH METHODS

Qualitative research, utilised during the initial stage, established issues of concern as perceived by users of the maternity provision. These focus groups were used effectively as an exploratory tool (Easterby-Smith Thorpe and Lowe, 1991) providing rich data on which to develop further research. The author was able to

identify factors which may have informed the consumers expectations, such as referent groups and experience. This data was then developed using "before" childbirth and "after" childbirth in-depth interviews with a different sample than that used for the focus groups. The same individuals were interviewed, before and after the birth, to consider changing expectations as a result of experience. Finally, a survey was developed and analysed using SPSS to substantiate use of referent groups, expectations and levels of satisfaction of the maternity service provision.

The importance of identifying issues which are important to patients, the significance of communication and the direct and indirect effects on the delivery of care to patients continue to be significant (Wilcock, 1998). Awareness of the need to consider quality issues and the ability to identify opportunities for successful strategic implementation are also key to improvement of health care provision.

Key areas for improvement in communication between users and providers were highlighted using triangulation of data. In addition, four major hypotheses were tested in the final stage of research, significantly substantiating qualitative analysis.

8.3 LIMITATIONS OF THE STUDY

This research was designed to examine in detail, for the first time, the application of novices and expert categories as users of the maternity provision. It established issues concerning users of the maternity provision and identified differences in expectations and perceptions amongst user categories. This study also demonstrated varying use of formal and informal referent groups.

Essentially the concern of the research design was to include responses from the widest possible sample of users of the maternity services. The limitations of this study were principally as a result of timing. The main limitations of the research are:

Health care and approaches to quality and service improvement is a large and complex area. Although only one service, namely the maternity provision, was the focus for this study, all aspects of health care cannot be addressed in one piece of research. Considering user categories, issues such as the clinical and cost effectiveness of providing a service to match their expectations were not key elements of the collated data. They are extremely important issues, yet to concentrate on them would have distracted the focus from the main research aims and objectives.

The study concentrated on the expectations, perceptions and levels of satisfaction of women who had experienced, or were experiencing, the maternity provision and the methodology of triangulation of data was considered to be most appropriate to substantiate the findings. However, as a result of access difficulties, and as a result of trying to sample a wide selection of users, the research did not consist of enough longitudinal data.

That is, the in-depth interviews that followed the same individuals throughout the process of their maternity provision was most useful in establishing changes in expectations and perceptions. Although the research would have been qualitative in nature, a study which focused on a larger number of individuals before and after their childbirth experience would have perhaps provided a greater depth of perceptions, in addition to expectations and levels of satisfaction.

Future research should not only focus on expectations and levels of satisfaction of users of a service provision, but should also concentrate on measuring change in expectations and perceptions to identify the principle factors affecting change.

The study, although determining differences in expectations and levels of satisfaction that were attributable to social and cultural differences, (in addition to experience), did not address many of the complex sociological issues which

influence overall perception. Social control, social support, and the extent of social influence on user expectation and perception were outside the confines of this research. Social issues, however, may be key to understanding the development of expectations and the normalising of perceptions.

The study was limited by constraints of time and resources. Two hospitals were key in providing access, whilst the qualitative sampling involved obtaining respondents through antenatal and postnatal groups and university personnel. Although a UK wide study was considered for the questionnaire, guidelines laid down by various ethics committees made the replication of studies in Scotland and England unrealistic. Whilst the generalisability of these findings to other units can be questioned, the range of respondents included in this triangulation of data provide a basis to develop further studies on novice and expert users.

In the survey, the sample included a wide range of women having recently experienced childbirth on a postnatal ward. This allowed a large number of women to be accessed over a short period of time as service provision is perishable and varies between one experience and another. To main consistency in environment, facilities and number of other patients using the provision at the same time, the postnatal ward was appropriate. In replication studies, however, the use of a longitudinal study should be initially considered as the same individuals would be followed throughout the maternity process.

However, it is acknowledged that if a *large* scale survey of two separate groups was conducted during the antenatal period and the postnatal period, it would be representative enough not to have to use the same individuals before and after the event.

8.4.1. Research Implications

8.4.1.1 The Social Context

Interest in the social and cultural aspects of health care and their influence on users' expectations and perceptions have been detailed in the literature. Users of the maternity provision vary in age, occupation, health, education, disposable income and residential area and the extent to which these factors influence health provision continues to be of interest to social theorists (Lewis & Rook, 1999).

The role that social relationships have had in promoting health has been considered for decades (Burgess, 1926). Findings that confirmed the influence of social networks on health outcomes (Berkman & Syme, 1979 and House, Robbins & Metner, 1982) encouraged the debate on the link between social relationships and health.

Rook & Pietromonaco (1987) observed that just as social support may contribute to health care by alleviating stress, social control may contribute to health by discouraging health-compromising behaviour and promoting enhancing behaviour.

As the respondents in this research demonstrated varying dependence on formal and informal referent groups, the social support and social control provided by these groups may have influenced the behaviour of the participants. Consequently, social networks may have influenced research participants use, and consequently their perceptions, of the maternity provision.

The dismissive attitude towards antenatal classes by categories identified within the confines of the research may have been influenced by social control. Social influence on health compromising practices have been observed (Cohen, 1988), although social control literature has tended to focus on health enhancing influences rather than health-compromising influences. Rook & Lewis (1999)

suggest that, as a result of their findings, social control dynamics that surround health enhancing and health compromising behaviour are sufficiently different to warrant attention in future studies. The application and use of Social Control Theory to develop a deeper understanding of referent group influences, positive or negative, on behaviour and perception could be considered (See **Table 8.1**).

Main Contributions of this Research	*Future Research*
• The Matrix and the Location and Referent Group Affects on the Theory of Planned Behaviour Model developed in this study is based on extensive qualitative and quantitative research with current and past users' of the service • This study acknowledges the importance of experience in both expectations and levels of satisfaction, comparing novice and expert categories • The perceptions of women from various socio-economic groupings were taken into account • Recurrent themes and key ideas were explored through qualitative research and substantiated using triangulation of data • This study explored the views of antenatal and postnatal women regarding important attributes of the entire service experience	**Social Context** • Influence of social networks on health outcomes should be explored using the level of dependence on formal and informal reference group as a grounding **Health Services Context** • Further studies on the implications of novice/expert user could provide data on user behaviour and more accessible channels of communication • Priorities and "trade-offs" could be further explored with a view to providing a greater perceived quality of service • Additional research into the use of the birth plan as a tool for identifying expectations could develop the birth plan into an important element of the debriefing process

Table 8.1: Contribution to Knowledge and Future Research

8.4.1.2 The Health Services Context

The majority of users of the maternity provision have a normal childbirth experience and a healthy outcome. As such, this research focused on this section of the service user. However, issues of concern for users of the service who become ill during their pregnancies, those who have multiple births or those who do not experience positive birth outcomes could be considered. Similarly the

application of the categories of novice and expert user could be implemented to assess the use of experience in these particular situations.

The profile of respondents, although from a variety of residential areas, were all able to speak English. Expectations and perceptions of users of the service who do not have English as their first language should be considered in depth. Previous experience and use of referent groups throughout the process should also be measured.

The Location and Referent Group Affects on the Theory of Planned Behaviour (**Figure 7.1**) indicates three sources of information for users and potential users of the maternity provision. Formal referent groups are used by novices resident in higher ACORN areas. Formal groups are used by experts resident in higher ACORN areas but not to the same extent as novices. Novices and Experts in lower ACORN groups are likely to use informal referent groups as a source of information. Novice and expert residents in higher ACORN areas are more likely to use literature as a source of information. In comparison, novice and expert residents in lower ACORN areas are not dependent on literature as a source of information.

The way in which novices and experts are dependent on this group (s) for information, could provide greater insight into the variety of communication channels available to and for users and providers of the service.

This study demonstrated a poor understanding of the Patient's Charter and suggested users of this service provision were unlikely to be aware of what they could expect from the service provision. The research also indicated that the respondents were less concerned with choice and more concerned with empathy, sensitivity and professionalism. Further research into forming more open channels of communication between policy makers, providers and users of the service is worthy of exploration.

Additional research into the use of the birth plan as a tool for identifying expectations, could provide enough information to develop the birth plan into an important element of the debriefing process.

Finally, the women in this research indicated that their service experience was influenced by the way in which they perceived staff to deal with other patients as well as the service provision they received themselves. This particularly sensitive issue is one which may be considered through training with regard to cultural and social issues.

8.4.1.3 Service Implications

A number of issues arose from the discussion on maternity provision which have important implications for the delivery of the maternity services. The short discussion which follows has scope for expansion but concentrates on the aspects of communication between service providers and service users.

On the whole, women were satisfied with the service provision they received during their pregnancy, labour and postnatal stay in hospital and some aspects of care, such as support during labour, were considered to be very well delivered. The staff should be aware that users of the maternity provision "trade-off" areas of discontent if positive expectations are fulfilled in areas of importance to the user. Communication to identify these areas of importance needs to be facilitated. This also supports the argument for continuity of care.

The majority of respondents in this study did not complete a birth plan. Those who did were identified as first time (novice) mothers who attended antenatal classes whilst pregnant. Whitford & Hillan (1998) demonstrated the significance of users' perception of the birth plan, concluding in their research that, although women completing a birth plan did not feel it affected the amount of control they had

during labour, it was useful for communication purposes. Similarly, Kitzinger (1998) advocates birth plans as having the potential to be an educational process for all concerned. A greater understanding of the potential of birth plans by users and staff could positively encourage communication.

Users of the maternity provision clearly used a variety of formal and informal referent groups to source information about their antenatal, labour and postnatal experience. For users' more trusting of informal information, barriers to communication with formal referent groups exist. These barriers include the perception, of the user, that they will be perceived as uneducated or that the information they will be given by formal sources is conflicting and out-dated. In an effort to communicate to all service users, these barriers must be overcome.

Finally, experienced mothers (experts) are a source of information and support for other experts and novices. The experience of experts is key to developing their own future expectations but also in supporting other categories of user. Recognising the value of experts, and their role in the communication process, may facilitate the identifying and fulfilment of realistic expectations.

SUMMARY

Three distinct methods were employed to examine users' expectations and perceptions of the maternity provision. Maternity services are used by women going through a life changing process. For novice users, this is typically their first ever experience of hospital or their first experience since their childhood. The user has varying expectations of the service during their antenatal period, their labour and the initial postnatal phase. The provision is all encompassing and includes technical, emotional and professional support, in varying degrees, throughout the three phases of the process.

Through both qualitative and quantitative methods, an expectations matrix has been developed. The Location and Referent Group Affects on the Theory of Planned Behaviour model also identified significant findings for the use of information and the developing of expectations. Service quality dimensions affecting expectations and overall perceptions of service experience were explored in the qualitative phases. Using these expectations and levels of satisfaction, this study has contributed to the body of knowledge regarding types of user, service quality and maternity provision.

Bibliography

Aaker D.A & Day G.S (1990) Marketing Research John Wiley and Sons, New York, 4th Edition

Abdellah F.G. and Levine E. (1957) "Developing a Measure of Patient and Personnel Satisfaction with Nursing Care" Nursing Research Vol.5 No.3 pp 100-108

Aharony L. and Strasser S. (1993) "Patient Satisfaction: What we Know About and What we Still Need to Explore" Medical Care Review Vol.50 No.1 pp49-79

Ajzen I. & Fishbein M. (1980) Understanding Attitudes and Predicting Social Behaviour Prentice Hall, New Jersey

Ajzen I. (1988) Attitudes, Personality and Behaviour Open University Press, Milton Keynes

Alexander L., Sandridge J. and Moore L. (1993) "Patient Satisfaction: An Outcome Measure for Maternity Services" Journal of Perinatal Neonatal Nursing Vol.7 No.2 pp28-39

Andaleeb S.S. (1994) "Hospital Advertising: The Influence of Perceptual and Demographic Factors on Consumer Dispositions" Journal of Service Marketing Vol.8 No.1 pp 48-59

Appleby J. (1996) A Measure of Effectiveness? A Critical Review of the NHS Efficiency Index National Association of Health Authorities and Trusts

Armistead C.G. (1989) "Customer Service and Operations Management in Service Businesses" The Service Industries Journal Vol.9 No.2 pp247-260

Assael H. (1992) Consumer Behaviour and Marketing 4th Edition, New York University, PWS Co. Kent

Audit Commission (1993) Their Health Your Business: The New Role of the District Health Authority National Health Service Report No.11 HMSO

Avis M. and Bond M. (1995) "Exploring Patient Satisfaction With Out-Patient Services" Journal of Nursing Management Vol.3 pp59-65

Azeem Majeed F., Chaturvedi N., Reading R. & Ben Shlomo Y. (1994) "Monitoring and Promoting Equity in Primary and Secondary Care" British Medical Journal No.308 pp1426-1429

Bagozzi R.P. (1982) "A Field Investigation of Casual Relations Among Cognitions, Affect, Intention and Behaviour" Journal of Marketing Research Vol.5 No.19 pp562-584

Bagozzi R.P. (1994) Principles of Marketing Research Blackwell Publishers, Massachusetts.

Bagozzi R.P. & Li Y. (1988) "On the Evaluation of Structural Equation Models" Journal of the Academy of Marketing Science Vol. 16 No.1 pp74-94

Bakketeig L.S. (1992) "Methodological Problems and Possible Endpoints in the Evaluation of Antenatal Care" International Journal of Technology Assessment in Health Care Vol.8 pp33-39

Ball J.A. (1987) Reactions to Motherhood - The Role of Postnatal Care Cambridge University Press, Cambridge

Bamford C. & Jacoby A. (1992) "Development of Patient Satisfaction Questionnaires: 1 Methodological Issues" Quality in Health Care Vol.1 pp153-157

Barley P. (1994) "Looking for Trouble" Marketing Business September pp21-24

Barnes M. & Prior D. (1995) "Spoilt for Choice? How Consumerism Can Disempower Public Service Users" Public Money and Management July-September pp53-58

Barsalou L.W. (1983) "Ideals, central tendency and frequency of instantation as determinants of graded structure in categories" Journal of Experimental Psychology: Learning, Memory and Cognition II pp629-654

Beard R.(1992) Pregnancy Care in the 1990s The Partheon Publishing Group, Lancaster, England

Beech B.A. (1984) Perinatal Services and Prenatal Care - User Perspective Association for the Improvements in the Maternity Services

Beech B.A. (1985) The Role of Consumer Advocacy in Birth Care Association for the Improvements in the Maternity Services

Beech B.A. (1985) Birth as a Normal Process - User Perspective Association for the Improvements in the Maternity Services

Bell J. (1993) Doing Your Research Project Open University Press, Buckingham

Bell L., Morris B. & Berman Brown R. (1993) "Devising a Multidisciplinary Audit Tool" International Journal of Health Care Quality Assurance Vol.5 No.4 pp 16-21

Bennett A.R. (1993) "Marketing: Can There Ever Be a Real Exchange of Values in the Health Service?" International Journal of Health Care Quality Assurance Vol.6 No.3 p17-19

Berry L. (1980) "Services Marketing is Different" Business May-June pp24-29

Berry L.L., Zeithaml V.A. & Parasuraman A. (1990) "Five Imperatives for Improving Quality Service" Sloan Management Review Vol.31 No.4 pp29-38

Bitner M., Booms B.H. & Stanfield Tetreault M. (1990) "The Service Encounter: Diagnosing Favourable and Unfavourable Incidents" Journal of Marketing Vol.54 No.1 pp71-85

Bitran G. & Lojo M. (1993) "A Framework for Analysing the Quality of the Customer Interface" European Management Journal Vol.11 No.4 pp385-396

Bolton R.N. & Drew J.H. (1991) "A Longitudinal Analysis of the Impact of Service Changes on Customer Attitudes" Journal of Marketing Vol.55 No.1 pp1-9

Bolton R.N. and Drew J.H. (1991) "A Multistage Model of Customers' Assessments of Service Quality and Value" Journal of Consumer Research Vol.17 pp375-384

Boulding W., Kalra A., Staelin R. & Zeithaml V.A. (1993) "A Dynamic Process Model of Service Quality: From Expectations to Behavioural Intentions" Journal of Marketing Research Vol. 30 pp7-27

Brant S. (1992) "Hearing the Patient's Story" International Journal of Health Care Quality Assurance Vol.5 No.6 pp5-7

Britten N. & Shaw A., (1994), "Patient's Experience of Emergency Admission: How Relevant is the British Government's Patient's Charter?" Journal of Advanced Nursing, 19(6): pp36-37

Bryman, A, and Burgess R (1994) Analyzing Qualitative Data Routledge, London

Bristol T. & Fern E.F.(1996) "Exploring the Atmosphere Created by Focus Group Interviews: Comparing Consumers' Feelings Across Qualitative Techniques" Journal of Market Research Society Vol.38 No.2 pp185-195

Brooks L. & Black M. (1994) "Local Delivery" Health Service Journal pp17

Brown S.W., Fisk R.P. & Bitner M.J. (1994) "The Development and Emergence of Services Marketing Thought" International Journal Service Industry Management Vol. 5 No. 1 pp21-48

Burgess, R.G. (1982) Field Research: a Sourcebook and field Manual London: Unwin Hyman

Burns T. (1992) "Researching Customer Service in the Public Sector" Journal of Market Research Society Vol.34 No.1 pp52-60

Cadotte E.R., Woodruff R.B. & Jenkins R.L.(1987) "Expectations and Norms in Models of Customer Satisfaction" Journal of Marketing Research Vol.24 pp305-314

Cardozo L. (1993) "Is Routine Induction of Labour at Term Ever Justified?" British Medical Journal Vol.306 pp840-841

Carhill R., Dixon P. & Jefferson S. (1989) The NHS and its Customers Customer Feedback Studies, Centre for Health Economics, University of York

Carmen J.M. (1990) "Consumer Perceptions of Service Quality: An Assessment of the SERVQUAL Dimensions" Journal of Retailing Vol.66 No.1 pp33-55

Carr-Hill R.A. (1992) "The Measurement of Patient Satisfaction" Journal of Public Health Medicine Vol.14 No.3 pp236-249

Cartwright A. (1988) "Interviews or Postal Questionnaires? Comparisons of Data about Women's Experiences with Maternity Services" The Millbank Quarterly Vol.66 No.1 pp172-189

Cave M., Copley G & Hanney S. (1995) "Setting Quality Standards in the Public Sector: Some Principles and an Application" Public Money and Management Vol.15 No.1 pp29-34

Charles J. and Curtis L. (1994) "Birth Afterthoughts: Setting Up A Listening Service" Midwives Chronicle and Nursing Notes Vol.107 No.1278 pp266-268

Chase R.B. (1978) "Where Does the Customer Fit in a Service Operation?" Harvard Business Review Vol. 56 Nov-Dec pp137-142

Clark F. (1993) "Quality and Service in the Public Sector" Public and Finance Accountancy October pp2-4

Cleary R., Beard R., Coles J., Devlin B., Hopkins A., Schumacher D. & Wickings I. (1994) "Comparative hospital databases: Value for management and quality" Quality in Health Care Vol.3 pp3-10

Clow K.E. & Beisel J.L. (1995) "Managing Consumer Expectations of Low Margin, High Volume Services" Journal of Services Marketing Vol.9 No.1 pp33-46

Collier D.A.(1991) "New Marketing Mix Stresses Service" The Journal of British Strategy Vol.12 No.2 pp42-45

Commission for Racial Equality (1994) Race Relations Code of Practice in Maternity Services, London

Coote A. & Hunter D.J. (1996) New Agenda for Health Institute for Public Policy Research, London

Cronin J.J. jnr. & Taylor S.A. (1992) "Measuring Service Quality: A Re-examination and Extension" Journal of Marketing Vol.56 No.3 pp55-68

Cronin J.J. jnr. & Taylor S.A. (1994) "SERVPERF VERSUS SERVQUAL: Reconciling Performance-Based & Perceptions-Minus-Expectations Measurement of Service Quality" Journal of Marketing Vol.58 pp125-131

Crosby L.A., Evans K.R. & Cowles D. (1990) "Relationship Quality in Services Selling: An Interpersonal Influence Perspective" Journal of Marketing Vol.54 pp68-81

Daniel W.W. & Terrell J.C (1992) Business Statistics: For Management and Economics Sixth Edition, Houghton Mifflin Company, USA

Davies H.T. & Nultey S.M (1999) "The Rise and Rise of Evidence in Health Care" Public Money and Management No.1 pp9-16

Department of Health Changing Childbirth: Part 1 Report of the Expert Maternity Group, (1993) HMSO, London

Dickinson E.(1995) "Using Marketing Principles for Healthcare Development" Quality in Health Care Vol.4 No.1 pp40-44

Dimond B. (1999) "The NHS White Paper and the Midwife" British Journal of Midwifery Vol.7 No.2 pp74-76

Dion P.A., Javalgi R. & Dilorenzo-Aiss J. (1998) "An Empirical Assessment of the Zeithaml, Berry and Parasuraman Service Expectations Model" The Service Industries Journal Vol 18 No.4 pp66-86

Dotchin J.A. & Oakland J.S (1994) "Total Quality Management in Services – Part 1: Understanding and Classifying Services" International Journal of Quality and Reliability Management Vol 11 No.3 pp9-26

Donabedian A. (1966) "Evaluating the Quality of Medical Care" Millbank Quarterly Vol. 44 No.3 pp166-203

Donabedian A. (1980) "Explorations in quality assessment and monitoring" Arbor, MI: Health Administration Press

Donabedian A. (1982) "The criteria and standards of quality" Arbor, Health Administration Press

Donabedian A (1988) "Quality Assessment and Assurance: Unity of Purpose, Diversity of Means" Inquiry Vol. 25 pp173-92

Donabedian A. (1992) "Quality Assurance in Health Care: Consumers Role" Quality in Health Care Vol.1 pp247-251

Douglas S.P. (1976) "Cross-National Comparisons of Consumer Stereotypes: A Case Study of Working and Non-Working Wives in the US and France" Journal of Consumer Research June

Doyle K. & Kliener B.H. (1994) "Managing for Excellence in the Public Sector" Management Research News Vol.17 No.1/2 pp25-32

Drew N.C., Salmon P. & Webb L. (1989) "Mothers', midwives' and obstetricians' views on the features of obstetric care which influence satisfaction with childbirth" British Journal of Obstetrics and Gynaecology Vol.96 pp1084-1088

Dube L., Belanger M.C.& Trudeau E. (1996) "The Role of Emotions in Health Care Satisfaction" Journal of Health Care Marketing Vol.16 No.2 pp45-51

Dunlop W. (1993) "Changing Childbirth – Commentary II" British Journal of Obstetrics and Gynaecology No. 100 pp1072-1074

East R. (1990) "Using attitude-behaviour methods in consumer research" Proceedings of the 23rd Marketing Education Group Conference, Oxford Polytechnic pp 337-347

East R. (1992) Changing Consumer Behaviour, Kingston University, Cassell Education Ltd.

East R. (1992) "The Effect of Experience on the Decision Making of Expert and Novice Buyers" Journal of Marketing Management Vol. pp167-176

Easterby Smith M., Thorpe R. & Lowe A. (1991) Management Research: An Introduction Sage Publications, London

Eccles M., Jacoby A. & Bamford C. (1992) "Development of Patient Satisfaction Questionnaires: 2 Collaboration in Practice" Quality in Health Care Vol.1 pp158-160

Edgett S. & Parkinson S. (1993) "Marketing for Service Industries - A Review" The Service Industries Journal Vol.13 No.3 pp19-39

Elliot K.M., Hall M.C. and Stiles G.W. (1992) "Service Quality in the Health Care Industry: How Are Hospitals Evaluated by the General Public?" Journal of Hospital Marketing Vol.7 No.1 pp113-124

Ellis R. & Whittington D. (1994) "Health Care Quality Assurance: Techniques and Approaches" Public Money and Management April-June pp23-29

Ennis M. & Vincent C.A. (1990) "Obstetric accidents: a review of 64 cases" British Medical Journal Vol.300 pp1365-1367

Evans R.H. (1982) "Diagnosing Customer Satisfaction/Dissatisfaction & Behavioural Intention: Expectancy Value Theory Versus Equity Theory" International Fare in Customer Service and Complaining Behaviour, Syracuse University

Feinmann J. (1997) Surviving The Baby Blues Wardlock, London

Fielding N.G. & Fielding J.L. (1986) Linking Data Sage Publications, London

Fielding N.G. & Fielding J.L. (1990) Linking Data Sage Publications, London

Fishbein M.(1976) "Extending the Extended Model: Some Comments" ACR III, University of Illinois, Urbana-Champaign pp491-497

Fitzpatrick R.(1991) "Surveys of Patient Satisfaction 1 - Important General Considerations" British Medical Journal Vol.302 pp887-889

Folkes V.S. (1984) "Consumer Reactions to Product Failure: An Attributional Approach" Journal of Consumer Research Vol.10 pp398-409

Ford C., Iliffe S. & Franklin O. (1991) "Outcome of Planned Home Births in an Inner City Practice" British Medical Journal Vol.303 pp1517-1519

Fornell C. (1992) "A National Customer Satisfaction Barometer: The Swedish Experience" Journal of Marketing Vol.56 No.1 pp6-21

French K. (1981) "Methodological Considerations in Hospital Patient Opinion Surveys" International Journal of Nursing Studies Vol.18 No.1 pp7-32

Gabbott M. & Hogg G. (1998) Consumers and Services Wiley & Sons, Chichester

Gaster L. (1995) Quality in Public Services Open University Press, Buckingham

Ghobadian A., Speller S. & Jones M. (1994) "Service Quality: Concepts and Models" International Journal of Quality and Reliability Management Vol.11 No.9 pp43-66

Gill J. & Johnson P. (1991) Research Methods for Managers Paul Chapman Publishing, London

Gilly M.C., Cron W.L. & Barry Th E. (1983) "The Expectations-Perception Comparison Process: An Investigation of Expectation Types" in Day R.L. & Hunt H.K. International Fare in Consumer Satisfaction & Complaining Behaviour Indiana University, Bloomington pp10-16

Glaser, G. & Strauss, A.L. (1967) Discovery of Grounded Theory: Strategies for Qualitative Research Chicago: Aldine

Glazer G. (1995) "The Impact of the NHS reforms on Patient Care: A View from a London Teaching Hospital" in Murley R. Patients or Customers: Are the NHS Reforms Working? The Institute of Economic Affairs and Welfare Unit, London

Gordon W. & Langmaid R. (1988) Qualitative Market Research Gower

Goyert G.L., Bottoms S.F., Treadwell M.C. & Nehra P.C. (1989) "The Physician Factor in Caesarean Birth Rates" New England Journal of Medicine No.320 pp706-709

Gronroos C. (1984) "A Service Quality Model and its Marketing Implications" European Journal of Marketing Vol.18 No.4 pp36-44

Gronroos C. (1990) Service Management and Marketing, Lexington Books, Lexington

Graham C., Lyall D. & Puxty A.G. (1992) "Cost Control: The Manager's Perspective" Management Accounting October

Graham P. (1994) "Marketing in the Public Sector: Inappropriate or Merely Difficult?" Journal of Marketing Management Vol.10 pp361-375

Green J.M., Coupland V.A. & Kitzinger J. (1990) "Expectations, Experiences and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women" Birth Vol.17 No.1 pp15-24

Green J.M. (1993) "Expectations and Experiences of Pain in Labor: Findings From a Large Prospective Study" Birth Vol.20 No.2 pp.65-72

Green Hobart D. (1994) "Managing Health Care -the Biggest Problem in the World" The Journal of the Public Enterprise Group No.42 pp6-11

Griffiths R., (1983) NHS Management Inquiry London DHSS

Gummesson E. (1991) Qualitative Methods in Management Research Sage Publications, London

Hall C. & Dornan M. (1988) "What Patients Like About Their Care and How Often They are Asked: A Meta Analysis of the Satisfaction Literature", Social Science and Medicine, Vol. 27 No. 9 pp 935-939

Hall A.M., Yudkin P.L., Bull D.J., Barlow D.H., Charnock F.M. & Gillmer M.D. (1993) "Evaluating a Policy of Reduced Consultant Antenatal Clinic Visits for Low Risk Multiparous Women" Quality in Health Care Vol.2 pp152-156

Hall J.A.& Dornan M.C. (1988) "What Patients Like About Their Medical Care and How Often They Are Asked: A Meta-Analysis of the Satisfaction Literature" Social Science and Medicine Vol.27 No.9 pp935-939

Hall M., McIntyre S. & Porter M. (1985) Antenatal Care Assessed - A Study of an Innovation Aberdeen University Press

Ham C.(1991) The New National Health Service Radcliffe Medical Press, Oxford

Ham C. (1997) Management and Competition in the NHS Radcliffe Medical Press, Oxon

Hammond K.L.& Jurkus A.F. (1993) "Healthcare Professionals and the Ethics of Healthcare Marketing" Health Marketing Quarterly Vol.11 No.1/2 pp9-17

Harrison S., Hunter D.J., Pollitt C., (1990) The Dynamics of British Health Policy, London: Unwin Hyman

Harrison S. (1991) Managing the National Health Service: Shifting the Frontier? Chapman and Hall, London

Harrison S., Small N. & Baker M. (1994) "The Wrong Kind of Chaos? The Early Days of an NHS Trust" Public Money and Management Vol.14 No.1 pp39-46

Haynes R.A. & Duval P.K. (1992) "Service Quality Management: A Process Control Approach" International Journal of Service Industry Management Vol.3 No.1 pp14-24

Headley D.E.& Miller S.J. (1993) "Measuring Service Quality and its Relationship to Future Consumer Behavior" Journal of Health Care Marketing Vol.13 No.4 pp32-41

Health Committee 2nd Report Maternity Services (1993) Vol.1 HMSO

Heskett J.L. (1987) "Lessons in the Service Sector" Harvard Business Review March/April pp118-126

Heylen J.P., Dawson B. & Sampson P. (1995) "An Implicit Model of Consumer Behaviour" Journal of the Market Research Society Vol.37 No.1 pp51-67

Holbrook M.B. & Corfman K.P (1985) "Quality and Value in the Consumption Experience: Phaedrus Rides Again" in Jacoby J. & Olson J.C. Perceived Quality: How Consumers View Stores and Merchandise Heath, Lexington

Holt B.(1994) "Benchmarking Comes to HR" Personnel Management June pp32-35

Holt P.R. (1993) "Beyond Resource Management: Towards Total Quality" International Journal of Health Care Quality Assurance Vol.6 No.5 pp24-29

Hooley G.J.(1993) "Market-Led Quality Management" Journal of Marketing Management Vol.9 pp315-335

Hopkins A. (1993) "What Do We Mean By Appropriate Health Care?" Quality in Health Care Vol.2 pp117-123

Hopkins A., Gabbay J. & Neuberger J. (1994) "Role of Users of Health Care in Achieving a Quality Service" Quality in Health Care Vol.3 No.4 pp203-209

Humenick S.S.& Bugen L.A.(1981) "Mastery: The Key to Childbirth Satisfaction? A Study" Birth & the Family Journal Vol.8 No.2 pp84-90

Hutton E. (1994) "What Women Want From Midwives" British Journal of Midwifery Vol.2 No.12 pp608-611

Jacoby A. (1987) "Women's Preferences for and Satisfaction with Current Procedures in Childbirth - Findings From a National Study" Midwifery Vol.3 pp117-124

Jen B. (1992) "Health Technology Assessment" British Medical Journal Vol.305 pp67-69

Joby J.(1992) "Patient Satisfaction: The Impact of Past Experience" Journal of Health Care Marketing Vol.12 No.3 pp56-64

Johnston N.H., Venkat Narayan K.M. & Ruta D.A.(1992) "Development of Indicators for Quality Health Assurance in Public Health Medicine" Quality in Health Care Vol.1 pp225-230

Jones P. (1995) "Managing Customer-Customer Interactions Within the Service Experience" Management Research News Vol.18 No.12 pp54-59

Kahneman D. & Miller D.T. (1986) "Norm Theory: Comparing Reality to its Alternatives" Psychological Review Vol.93 No.2 pp136-153

Kelley S., Donnelly J. & Skinner S. (1990) "Customer Participation in Service Production and Delivery" Journal of Retailing Vol 66 No.3 pp315-335

Kennedy R. & Nicholls J.C. (1995) "The Efffects of the Purchaser/Provider Split on Patient Care" in Murley R. Patients or Customers: Are the NHS Reforms Working? The Institute of Economic Affairs and Welfare Unit, London

Kerssens J.J. (1994) "Patient Satisfaction with Home Birth Care in the Netherlands" Journal of Advanced Nursing Vol.20 No.2 pp344-350

Kinmond S., Aitchison T.C., Holland B.M., Jones J.G., Turner T.L. & Wardrop C.A. (1993) "Umbilical Cord Clamping and Preterm Infants: A Randomised Trial" British Medical Journal Vol.306 pp172-175

Kinnear T.C & Taylor J.R (1991) Marketing Research: An Applied Approach Prentice Hall, New Jersey, 2nd Edition

Kitzinger S. (1999) "Birth plans: how are they being used?" British Journal of Midwifery Vol 7 No.5 pp300-303

Knox S.D. & de Chernatony L. (1989) "Attitude, personal norms and intentions: an evaluation of their interactions in the mineral water market" Proceedings of the 22nd Annual Conference of the Marketing Education Group, Glasgow pp31-49

Koch H. (1991) "Obstacles to Total Quality Management in Health Care" International Journal of Health Care Quality Assurance Vol.4 No.3 pp30-31

Kotler P. (1982) Principles of Marketing Prentice Hall, New Jersey

Kunst P. & Lemmink J. (1995) Managing Service Quality Paul Chapman Publishing, London

Kunst P. & Lemmink J. (1996) Managing Service Quality Volume 2 Paul Chapman Publishing, London

La Monica E.L., Oberst M.T., Madea A.R. & Wolf R.M. (1986) "Development of a Patient Satisfaction Scale" Journal of Research in Nursing and Health Vol.9 No.1 pp43-50

Lauermann E. (1993) "Managing Change: The Human Aspects of the NHS" British Medical Journal Vol.306 pp130-132

Lehtinen U. & Lehtinen J.R. (1991) "Two Approaches To Service Quality Dimensions" Service Industries Journal Vol 11 No.3 pp287-303

Leon J.L. & Olabain E. (1993) "The Validity of Consumer Predicting Variables Used in Marketing Research" Marketing and Research Today February pp4-13

Levitt, T., (1972) "Production Line Approach to Services" Harvard Business Review, September-October 1972

Lewis M.A. & Rook K.S. (1999) "Social Control in Personal Relationships: Impact on Health Behaviours and Psychological Distress" Health Psychology Vol 18 No.4 pp63-71

Liljander V. & Standvik T. (1992) "Estimating Zones of Tolerance in Perceived Service Quality and Perceived Value" Working Paper 247, Swedish School of Economics and Business Administration

Lin B. & Kelly E. (1995) "Methodological Issues in Patient Satisfaction Surveys" International Journal of Health Care Quality Assurance Vol.8 No.6 pp32-37

Linder-Pelz S. (1982a) "Towards a Theory of Patient Satisfaction" Social Science and Medicine Vol. 16 pp577

Linder-Pelz S. (1982) "Social psychological determinants of patient satisfaction: a test of five hypotheses" Social Science and Medicine Vol.16 pp583

Liswood L.A.(1989) "A New System for Rating Service Quality" The Journal of Business Strategy pp42-46

Lockhart, D.C. & Russo, R.J. (1994) Mail and Telephone Surveys in Marketing Research: A Perspective Form the Field Principles of Marketing Research edited: Bagozzi, R., Blackwell Publishers, Massachusetts

Lockyer, K., (1986) "Service – A Polemic and Proposal" International Journal of Operations & Production Management, Vol. 6 No. 3, pp5-9

Loudon D.L. & Della Bitta A.J. (1993) Consumer Behaviour - Concepts and Applications 4th Edition, McGraw Hill, New York

Lovelock C. (1996) Services Marketing Prentice Hall

Lowry S. (1993) "Trends in Health Care and their Effect on Medical Education" British Medical Journal Vol.306 pp255-258

Ludwig-Beyner P., Ryan C.J. & Johnson N.J. & (1993) "Using Patient Perceptions to Improve Quality Care" Journal of Nursing Care Quality Vol.7 No.2 pp42-51

Lumley J. (1985) "Assessing Satisfaction with Childbirth" Birth Vol.12 No.3 pp141-145

Lytle R.S. & Mokwa M.P.(1992) "Evaluating Health Care Quality: The Moderating Role of Outcomes" Journal of Health Care Marketing Vol.12 No.1 pp4-14

Malhotra N.K. (1993) Marketing Research: An Applied Orientation Prentice Hall, New Jersey

Manstead A.S.R., Proffitt C. & Smart J.L. (1983) "Predicting and understanding mothers' infant feeding intentions and behaviour: Testing the Theory of Reasoned Action" Journal of Personality and Social Psychology Vol. 44 pp657-671

Finally, in considering issues concerning women who had used the obstetric services since the implementation of *Working for Patients* (1991), the broad topic of facilities was raised. Facilities included postnatal ward information and aspects of cleanliness and sustenance.

Women would have preferred greater information on arriving on postnatal wards and there was no evidence to suggest, at the quantitative stage, that expert women would be more familiar with the hospital environment as a result of their previous experience (See **6.5**). All women were concerned with the food although this is typically an area of dissatisfaction and may not have been raised if the food was considered favourably. Similarly, concern with cleanliness featured in all three stages of empirical research and may have been less of an issue had there been satisfaction with this aspect of the provision.

7.2.9 Summary

The issues concerning women using the maternity provision are multi-faceted. The phases of service are distinct for the participants. There are a number of aspects which remain salient through the research and are presented in **Table 6.2**. This research has fulfilled the objective of establishing issues of concern for the users of the maternity provision.

7.3 TO EXPLORE THE USE OF FORMAL AND INFORMAL REFERENT GROUPS AND TO DEVELOP AN UNDERSTANDING OF THE CONSTRUCTS WHICH SHAPE WOMEN'S EXPECTATIONS AND OPINIONS OF OBSTETRIC SERVICES

East's categorisations were utilised to explore the experiences of novice and expert mothers to determine if, and to what extent, experience of a particular service influenced expectations and perceptions of that service provision.

Mark A. & Brennan R. (1995) "Demarketing: Managing Demand in the UK National Health Service" Public Money and Management Vol 3 pp17-22

Marshall B.S & Javalgi R.G. (1995) "The Market for Obstetrical Services: An Integrative Approach to Building Relationships" Journal of Services Marketing Vol.9 No.1 pp60-68

Martin C.R.& Horne D. (1992) "Restructuring Towards a Service Orientation: The Strategic Challenges" International Journal of Service Industry Management Vol.3 No.1 pp25-38

Mattsson J. (1992) "A Service Quality Model Based on an Ideal Value Standard" International Journal of Service Industry Management Vol.3 No.3 pp18-33

Maxwell J. (1992) "Dimensions of Quality Revisited: From Thought to Action" Quality in Health Care Vol.1 pp171-177

McAlister D.(1994) "Putting Health Economics into Quality" Public Money and Management Vol 2 pp15-22

McCracken, G., (1988) The Long Interview Sage Publications, London

McNulty T., Whittington R., Whipp R. & Kitchener M. (1994) "Implementing Marketing in NHS Hospitals" Public Money and Management Vol 3 pp51-57

MacStravic R.S (1984) Marketing by Managing Relationships Health Progress Vol.69 No.9 pp49-60

Meekings A. (1995) "Unlocking the Potential of Performance Measurement: A Practical Implementation Guide" Public Money and Management Vol.15 No.4 pp5-12

Melia R.J., Morgan M., Wolfe C.D.A. & Swan A.V. (1991) "Consumers' Views of the Maternity Services: Implications for Change & Quality Assurance" Journal of Public Health Medicine Vol.13 No.2 pp120-126

Merkel W.T. (1984) "Physician Perception of Patient Satisfaction: Do Doctors Know Which Patients Are Satisfied?" Journal of Medical Care Vol.22 No.5 pp453-459

Mersha T. & Adlaka V. (1992) "Attributes of Service Quality: The Consumers' Perspective" International Journal of Service Industry Management Vol.3 No.3 pp34-45

MIDRIS (1997) Evidence-Based Informed Choice in Maternity Care MIDRIS and the NHS Centre for Reviews and Dissemination, Bristol

Miles, M.B., & Huberman, M.A., (1994) An Expanded Sourcebook: Qualitative Data Analysis Sage Publications Inc. London

Miller J.A. (1977) "Studying Satisfaction, Modifying Models, Eliciting Expectations, Posing Problems and Making Meaningful Measurements" in Hunt H.K. Conceptualisation and Measurement of Consumer Satisfaction and Dissatisfaction Report No.77-103 (May) Marketing Science Institute, Cambridge, Massachusetts pp72-91

Moores B.(1986) Are They Being Served? Phillip Allan Publishers Ltd. London

Moores B.(1993) "Quality Management and Operational Research Initiatives in a Health Service Context" International Journal of Health Care Quality Assurance Vol.6 No.1 pp6-13

Moran M.(1994) "Re-shaping the Health Care State" Government and Opposition - An International Journal of Comparative Politics Vol.29 No.1 pp48-63

Morgan D.(1988) Focus Groups as Qualitative Research Sage Publications, California

Morgan G. & Smircich L. (1980) "The Case for Qualitative Research" Academy of Management Review Vol 5 No.4 pp491-500

MORI Health Research (1993) Study of Mothers Who Had Given Birth In England since April 1989 Unpublished

Morris B. (1989) "Aspects of Quality in Health Care" International Journal of Health Care Quality Assurance Vol.2 No.4 pp25-29

Moss F. (1992) "Achieving Quality in Hospital Practice" Quality in Health Care Vol.1 September Supplement pp17-19

Murphy-Black T. (1992) "Systems of Midwifery Care in Use in Scotland" Midwifery No.8 pp113-124

North Thames Regional Health Authority and the NCT (1995) "Birth Choices in North Essex: Findings of a Recent Research Project Carried Out by the National Childbirth Trust" Midwives Vol.108 No.1293 pp328

Oakley A. (1980) Women Confined Martin Robinson, Oxford

Oakley A. (1983) "Social Consequences of Obstetric Technology: The Importance of Measuring "Soft" Outcomes" Birth Vol.10 No.2 pp99-108

Oakley A. (1991) "Using Medical Care, The Views and Experience of High Risk Mothers" Health Services Review Vol.26 No.5 pp 651-669

O'Connor S.J.& Shewchuk R.M. (1991) "Comparing Service Quality Expectations in Hospitals and Health Care to Other Service Businesses" Journal of Hospital Marketing Vol.5 No.1 pp3-18

O'Connor Y. (1993) "Education for Parenthood - A Time for Change!" Midwives Chronicle and Nursing Notes Vol.106 No.1265 pp198-201

Oliver R.L. (1976) "Hedonic Reactions to the Disconfirmation of Product Performance Expectations: Some Moderating Conditions" Journal of Applied Psychology Vol.61 No.2 pp246-250

Olshavsky R. (1985) "Perceived Quality in Consumer Decision Making: An Integrated Theoretical Perspective" in Jacoby J. & Olson J.C. Perceived Quality: How Consumers View Stores and Merchandise Heath, Lexington

Omar M.A. & Schiffman R.F. (1995) "Pregnant Women's Perceptions of Prenatal Care" Maternal Child Nursing Journal Vol.23 No.4 pp132-142

O'Meara C. (1993) "An Evaluation of Consumer Perspectives of Childbirth and Parenting Education" Midwifery Vol.9 pp210-219

Oppenheim A.N. (1984) Questionnaire Design and Attitude Measurement, Heinemann, London

Ovretveit J. (1990) Health Service Quality Blackwell, London

Ovretveit J. (1988) Evaluating Health Interventions Open University Press, Buckingham

Parasuraman A., Berry L.L. & Zeithaml V.A. (1986) "A Conceptual Model of Service Quality and its Implications for Future Research" Journal of Marketing Vol.49 pp41-50

Parasuraman A., Berry L.L. & Zeithaml V.A. (1988) "Servqual: A Multiple Item Scale For Measuring Consumer Perceptions of Service Quality" Journal of Retailing Vol. 64 No. 1 pp 12-40

Parasuraman A., Berry L.L. & Zeithaml V.A. (1991) "Understanding Customer Expectations of Service" Sloan Management Review No.39 Spring pp1-12

Parasuraman A., Zeithaml V.A. & Berry L.L. (1994) "Re-assessment of Expectations as a Comparison Standard in Measuring Service Quality: Implications for Further Research" Journal of Marketing Vol.58 pp111-124

Pascoe G.C. (1983) "Patient Satisfaction in Primary Care: A Literature Review and Analysis" Evaluation and Program Planning Vol. 6 No. 3-4 pp185-210

Paterson C.M., Chapple J.C., Beard R.W., Joffe M., Steer P.J. & Wright C.S.W. (1991) "Evaluating the Quality of the Maternity Services - A Discussion Paper" British Journal of Obstetrics and Gynaecology Vol.98 pp1073-1078

Patton, M.Q., (1980) Qualitative Evaluation and Research Methods Beverly Hills, CA: Sage

Paxson, M.C., (1992) Follow-up Mail Surveys Industrial Marketing Management Vol. 20 pp 195-201

Peel Report (1970) Standing Maternity and Midwifery Advisory Committee Domiciliary Midwifery and Maternity Bed Needs London HMSO

Peyrot M., Cooper P.D. & Schnapf D. (1993) "Customer Satisfaction and Perceived Quality of Outpatient Health Services" Journal of Health Care Marketing Vol.13 pp24-33

Pitt C. (1993) "Quality Health Care: Identifying and Meeting Customer Needs" International Journal of Health Care Quality Assurance Vol.6 No.6 pp25-28

Powers T.L. (1988) "Identify and Fulfil Customer Service Expectations" Industrial Marketing Management Vol.17 pp273-276

Proctor S.R. Wright G.H. (1997) "A Qualitative Approach to Understanding the Dimensional Structure of Maternity Service Quality, Under Review" Nursing Review

Reynolds S. (1991) "The Ten Commandments of Customer Service" International Journal of Health Care Quality Assurance Vol.4 No.3 pp277-280

Ritchie J. & Spencer L. (1994) "Qualitative Data Analysis for Applied Policy Research" Chapter 9, Analysing Qualitative Data Ed. Bryman A. & Burgess R.G., Routledge, London

Robinson M.B., Sim F.M. & Chapple J. (1993) "Which Maternity Unit? Who Makes the Choice?" Journal of Public Health Medicine Vol.15 No.3 pp277-280

Rubin H.R. (1990) "Can Patients Evaluate the Quality of Hospital Care?" Medical Care Review Vol.47 No.3 pp267-326

Rust R., Zahonik A. & Kenningham T. (1996) Service Marketing Harper Collins, New York

Sage G.C. (1991) "Customer in the NHS" International Journal of Health Care Quality Assurance Vol.4 No.3 pp11-14

Schlesinger L.A. & Hesketh J.L. (1991) "Breaking the Cycle of Failures in Services" Sloan Management Review Vol.32 No.3 pp17-28

Scottish Consumer Council (1994) Consulting Consumers: A Guide to Good Practice for the NHS in Scotland, HMSO

Scottish Health Feedback (1992) Lothian Maternity Survey, Report to the Lothian Health Council

Scottish Office (1993) Provision of Maternity Services in Scotland: A Policy Review Health Policy and Public Health Directorate, Home & Health Department, HMSO

Shanks J. & Frater A. (1993) "Health Status, Outcome & Attributability: Is a red rose red in the dark?" Quality in Health Care Vol.2 pp259-262

Siehl C., Bowen D.E. & Pearson C.M. (1991) "The Role of Rites of Integration in Service Delivery" International Journal of Service Industry Management Vol.2 No.1 pp15-34

Simonson I. (1993) "Get Closer to Your Customer by Understanding How They Make Choices" California Management Review Vol 2 pp68-83

Singh J. (1990) "A Multifacet Typology of Patient Satisfaction With a Hospital Stay" Journal of Health Care Marketing Vol.10 No.4 pp8-21

Smith J.A. & Mitchell S. (1996) "Debriefing After Childbirth: A Tool for Effective Risk Management" British Journal of Midwifery Vol.4 No.11 pp581-586

Smith L.F.P. (1996) "Views of Pregnant Women on the Involvement of General Practitioners in Maternity Care" British Journal of General Practice Vol.46 No.403 pp101-104

Smith L.F.P. (1996) "Should General Practitioners Have Any Role in Maternity Care in the Future?" British Journal of General Practice Vol.46 No.405 pp243-247

Smith R.A. & Houston M.J. (1983) "Script-Based Evaluation of Satisfaction with Services", in Emerging Perspectives on Services Marketing, Berry L. et al, American Marketing Association, Chicago

Smith P. (1993) "Outcome-Related Performance Indicators and Organisational Control in the Public Sector" British Journal of Management Vol. 4 No. 3 pp58-69

Spencer A. (1996) "Using Consumer Feedback to Improve Services" International Journal of Health Care Quality Assurance Vol.9 No.1 pp29-33

Stevenson Marshall B. & Javalgi R.G. (1995) "The Market for Obstetrical Services: An Integrative Approach to Building Relationships" Journal of Services Marketing Vol.9 No.1 pp60-69

Swartz T.A. & Brown S.W. (1989) "Consumer and Provider Expectations and Experiences in Evaluating Professional Service Quality" Journal of the Academy of Marketing Science Vol.17 No.2 pp189-195

Taylor S.J. & Bogdan R. (1984) Introduction to Qualitative Research Methods John Wiley, New York

Taylor S. (1994) "Waiting for Service: The Relationship Between Delays and Evaluations of Service" Journal of Marketing Vol.58 pp56-69

Teas K.R. (1994) "Expectations as a Comparison Standard in Measuring Service Quality: An Assessment of a Reassessment" Journal of Marketing Vol.58 pp132-139

Tibbets J. (1994) "The Marketing Prescription" June Marketing Business

Thomas L.H., McColl E., Cullum N., Rousseau N., Soutter J. & Steen N. (1998) "Effect of clinical guidelines in nursing , midwifery, and the therapies: a systematic review of evaluations" Quality in Health Care Vol 7 pp183-191

Thompson A.G.H (1986) "The Soft Approach to Quality of Hospital Care" International Journal of Quality & Reliability Management Vol.3 No.3

Thomson R. & Bhopal R. (1993) "Improving Quality of Health Care: The Role of Public Health Medicine" Quality in Health Care Vol.2 pp35-39

Thornton J.G., Lilford R.J. & Johnson N. (1992) "Decision Analysis in Medicine" British Medical Journal Vol.304 pp1099-1103

Tomas G., Hult M. & Lukas B.A.(1995) "Classifying Health Care Offerings to Gain Strategic Marketing Insights" Journal of Services Marketing Vol.9 No.2 pp36-48

Tomes A.E. & Chee Peng Ng S. (1995) "Service Quality in Hospital Care: The Development of an In-Patient Questionnaire" International Journal of Health Care Quality Assurance Vol.8 No.3 pp25-33

Troutt B. (1994) "Choice & Control: A Midwife's View" Midwives Chronicle and Nursing Notes Vol.107 No.1282 pp416

Tse D.K. & Wilton P.C. (1988) "Models of Consumer Satisfaction Formation: An Extension" Journal of Marketing Research Vol.25 pp204-212

Turner P.D. and Pol L.G. (1995) "Beyond Patient Satisfaction" Journal of Health Care Marketing Vol.15 No.3 pp45-53

Vandamme R., Leunis J. (1993) "Development of a Multiple Item Scale for Measuring Hospital Service Quality" International Journal of Service Industry Management Vol.4 No.3 pp30-49

Vouri H. (1991) "Patient Satisfaction: Does it Matter?" Quality Assurance in Health Care Vol. 3 pp183

Walby S. & Greenwell J. (1994) Medicine and Nursing: Professions in a Changing Health Service Sage, London

Walker A.H. & Restuccia D. (1984) "Obtaining Information on Patient Satisfaction with Hospital Care: Mail versus Telephone" Health Services Research Vol 19 No.3 pp291-396

Walsh K. (1991) "Quality and Public Services" Public Administration Vol.69 Winter pp503-514

Walsh K. & Sheldon T. (1998) "Dealing with Clinical Risk: Implications for the Rise of Evidence-Based Health Care" Public Money and Management No.3 pp15-20

Ware J.E. and Snyder M.K. (1975) "Dimensions of Patient Attitudes Regarding Doctors and Medical Care Services" Journal of Medical Care Vol.13 No.8 pp669-682

Webb J.R (1992) Understanding and Designing Marketing Research Academic Press LTD., London

Wheeler N. & Proctor T. (1993) "Strategy Analysis in the Health Service" Journal of Marketing Management Vol.9 pp287-300

Whitford H.M. & Hillan E.M (1998) "Women's perceptions of birth plans" Midwifery No 14 pp248-253

Wilcock P. (1998) "Never mind the quality: feel the improvement" Quality In Health Care Vol 7 pp181

Wilderom C.P.M. (1991) "Service Management/Leadership: Different from Management/Leadership in Industrial Organisations?" International Journal of Service Industry Management Vol.2 No.1 pp6-14

Wilkie W.L. & Dickson P.R. (1985) "Shopping for appliances: consumers' strategies and patterns of information search" Marketing Science Institute Research Report No. 85-108, Cambridge, MA, MSI

Williams B. (1994) "Patient Satisfaction: A Valid Concept?" Journal of Social Science and Medicine Vol.38 No.4 pp509-516

Williamson C. (1992) Whose Standards? Consumer and Professional Standards in Health Care Open University Press

Woodside A.G., Frey L.L. & Daly R.T. (1989) "Linking Service Quality, Customer Satisfaction and Behavioral Intention" Journal of Health Care Marketing Vol.9 pp5-17

Zander L. & Chamberlain G Pregnancy Care for the 80s (1984) Royal Society of Medicine and MacMillan Press

Zeithaml V.A. (1981) "How Consumer Evaluation Processes Differ Between Goods and Services" in Donnelly J.H. & George W.R. Marketing of Services AMA, Chicago

Zeithaml V.A., Parasuraman A. & Berry L.L. (1988) "Communication and Control Processes in the Delivery of Service Quality" Journal of Marketing No. 2 pp35-48

Zeithaml V.A., Parasuraman A. & Berry L.L. (1991) "The Nature and Determination of Customer Expectations of Service" Marketing Science Institute Working Paper No.91-113 Marketing Science Institute, Cambridge

Zeithaml V.A., Berry L. & Parasuraman A. (1996) "The Behavioral Consequences of Service Quality" Journal of Marketing Vol.60 No.2 pp31-46

Appendices

Appendix 1

Framework Recurrent Themes & Indexing

KEY IDEAS

- EXPECTATIONS
- REFERENT GROUPS
- BENEFIT BELIEFS
- CONTINUITY OF CARE
- APPROACHABILITY
- AVAILABILITY OF ALTERNATIVES
- PREVIOUS EXPERIENCES
- IMPROVEMENTS IN SERVICE

Recurrent Themes During Antenatal Period

- CHOICE OF HOSPITAL
- TYPE OF BIRTH
- ANTENATAL CLASSES & ITS CONTENT
- ATTITUDE OF ANTENATAL STAFF
- WAITING TIMES FOR APPOINTMENTS
- AVAILABILITY OF INFORMATION
- USE OF BIRTH PLANS
- ATTITUDE OF PATIENT TOWARDS ANTENATAL STAFF
- LENGTH OF ANTENATAL VISITS
- EXPECTATIONS OF BIRTH AND A HEALTHY BABY
- REFERENT GROUPS
- AVAILABILITY OF ANTENATAL CLASSES
- ATTITUDE OF OTHER PATIENTS WITHIN ANTENATAL CLASSES
- ATTITUDE OF STAFF TOWARDS PARTNERS
- PARTNERS ATTITUDES TO FORTH COMING EVENTS
- EXPECTATIONS OF FACILITIES
- EXPECTATIONS OF STAFF ATTITUDES
- EXPECTATIONS OF ANTENATAL STAFF
- PRECONCEPTIONS OF PATIENTS BY STAFF
- EXPECTATIONS OF PAIN
- DOCTORS V MIDWIVES

Recurrent Themes During Labour

- FIRST PHONE CALL TO THE HOSPITAL
- PAIN
- INVOLVEMENT OF HUSBAND/PARTNER
- PAIN RELIEF
- TEMPERATURE IN HOSPITALS
- LOSS OF DIGNITY
- LOSS OF CONTROL
- MEDICAL STAFF AS EXPERTS
- DOCTORS V MIDWIVES
- ATTITUDE OF STAFF DURING LABOUR
- USE OF BIRTH PLAN
- EXPLANATION OF INTERVENTIONS
- USE OF STUDENTS
- HYGIENE OF STAFF
- AVAILABILITY OF NURSES DURING LABOUR
- AFFECT OF INFORMATION/EXPECTATIONS ON LABOUR
- FAMILY SUPPORT DURING LABOUR
- TRANSPORT
- TRAUMATIC BIRTHS (OTHER MOTHERS HAVE RELATED)

Recurrent Themes During the Postnatal Period

- BREAST FEEDING
- LENGTH OF STAY IN HOSPITAL
- TREATMENT OF PARTNERS/HUSBANDS
- ATTITUDE OF POSTNATAL STAFF TO PATIENTS
- PATIENTS ATTITUDES TO OTHER PATIENTS
- MOTHER AS PATIENT
- FOOD
- ROUTINE
- SAFETY AND SECURITY
- CLEANLINESS OF FACILITIES
- LACK OF FACILITIES
- AVAILABILITY OF NURSERY CARE
- USE OF QUESTIONNAIRES
- POSTNATAL SUPPORT
- ATTITUDE OF STAFF TOWARDS OTHER STAFF
- EASE OF USE OF SBCU
- EXTERNAL SERVICES
- WARD SIZES

TOPIC: CHOICE OF HOSPITAL

Choice:

Reasons for choice
Was a choice available

Main effects on choice:

Who played a part in the decision?
Motivation to comply?
Was a decision actually made?
What were the effects of experience/knowledge on the decision?

Identify items or activities of importance in choosing hospitals

Cleanliness

How important is hygiene?
What are the expectations of hygiene?
Are there different levels of acceptance of hygiene?
Are all hospitals the same?
Are excuses made by staff or patients?
Has it been improved since the Citizen's Charter was implemented?

Food

How important is diet?
Is diet a priority in relation to what has just happened?
What are the expectations of food?
Are problems regarding this addressed and overcome?
What is the affect of this on the patient?

Decor/Surroundings

What are the priorities?
What are the attitudes of staff and patient to using new equipment?
Have the surroundings changed for second time mothers?

Special Baby Care Units

Previous difficulties - experience of prior use?
Expectation of use?
Ease of access
Benefit beliefs

TOPIC: ANTENATAL PREPARATION (mental)

Preparation:

How much preparation has been carried out
Was the preparation as affected by referent groups

Main effects on Preparation:

Influence of expectations
Reasons for attending antenatal clinics and classes
Reasons for not attending antenatal classes
How does experience affect preparation?

Identify items or activities of importance in preparing for childbirth

Attendance

In what ways do antenatal classes affect or prepare the mother for birth?
Is male involvement a positive aspect?
Does the information given match expectations?
Are the timing and length of classes appropriate?
How does motivation to comply affect attendance?

Attitudes

What are the attitudes of those taking the classes?
For non-attendees, what are the preconceptions of attitudes
How do the attitudes of the group members affect other group members?
How is this dealt with?
Are birth plans considered to be important by the staff?
Are birth plans considered to be important by the patients?

TOPIC:ANTENATAL CARE (physical)

Care

Affect of care/treatment on overall service?
Expectations of care
Referent groups on attitude towards care
Motivation to comply with physical care

Main affects of care

The use of GP and the affects of shared care
Continuity of care and the expectations of continuity
Referent groups of the service and its affect on attitude towards care

Identify items or activities of importance in antenatal care

Appointments

Are appointments too long or too short in terms of expectation?
How does past experience affect expectation?
How long do patients expect to wait in term of referent groups?
What do women hope to receive from their antenatal care?
What do women receive from their antenatal care?
Are partners involved in appointments?

TOPIC: CARE DURING LABOUR

Labour:

Who played a major part
Did the length of labour affect the depth of care?
Was it as expected in terms of advice and information?
Use of referent groups during labour

Main effects of labour

Did it match expectations in terms of pain relief?
Were there motivations to comply with social norms?
Were there benefit beliefs in terms of leaving it to the experts?
Use of information from referent groups

Identify items or activities of importance during labour

Physical Affects

Was transport available to the hospital if necessary?
Was the temperature acceptable?
How was the first phone call to the hospital taken - was it as expected?
Was the pain as described?
Did the normative beliefs influence the physical aspects?
Was there interest in the birth plan?
Was it followed in physical terms?
Availability of nurses - were there too many/not enough?

Information

Was there enough information on pain relief?
Was there enough information about the effects of the relief on the baby?
Was this influenced by previous expectations or experience?
Was there enough information about the purpose of interventions?
Medical staff as experts and notion of credence

Mental Affects

Was there loss of dignity?
Was that expected?
Did use of referent groups prepare patients appropriately?
Has experience prepared women?
Hygiene of staff and facilities?
Attitude of staff and its affects on the patient
Use of students?
Use of partners and family support during labour

TOPIC: Postnatal Support (mental)

Support

What was available? Was the postnatal support as expected? Who were the referent groups - medical staff or other patients?

Main effects of support

What were the attitudes towards partners involvement? Were the expectations fulfilled? Was there enough advice/information postnatally? Motivation to comply postnatally?

Identify items or activities of importance in terms of support

Breast Feeding

Is it encouraged?
Are nurses available to help out?
Is the help adequate?
How do the other patients feel about it?

Employees

General availability?
Attitudes to each other - and its affects on the patients
Use of questionnaires - need for gratitude?
Treating the mother as a patient - as well as the baby
How flexible is the routine?
Do employees change with experience?
Do the mothers change their attitudes to the employees through experience?
How do the employees feel about the use of the nursery?

TOPIC: Postnatal Support (physical)

Support:

What was available? Was it as expected? What were the priorities to the patients during that postnatal period?

Main effects of support:

Did the women feel that the support was available? Was the support available from the medical staff or the other patients? Did the referent groups and information gained from them help during this period?

Identify items or activities of importance in terms of physical support

Routine

How flexible was the routine to accommodate the patients?
Has the routine changed over time for those experienced mothers?
What is the routine length of stay in hospital?
Does the length of stay vary with patients from different residential areas?
Does routine apply to visiting hours, in terms of length of stay and number of visitors?

Cleanliness

How important is hygiene?
Were the expectations of hygiene fulfilled?
Has it changed over time?

Facilities

Food and its availability
What facilities were expected postnatally?
Were expectations met?
What external services were available and how were they met by patients?
Use of SCBU and access
Were the ward sizes acceptable?
Were different ward sizes acceptable to different members of the residential groups?

INDEX **1.0 Patterns of Choice**

INDEX **2.O Antenatal Preparation**

INDEX **3.0 Attitudes to Antenatal Classes**

INDEX **4.0 Antenatal Staff**

INDEX **5.0 APPOINTMENTS**

INDEX **6.0 Preparation by Staff**

INDEX **7.0 Preparation by Patient**

INDEX **8.0 Physical Affects**

INDEX **9.0 Information**

INDEX **10.0 Mental Affects**

INDEX **11.0 Postnatal Support**

INDEX **12.0 Employees**

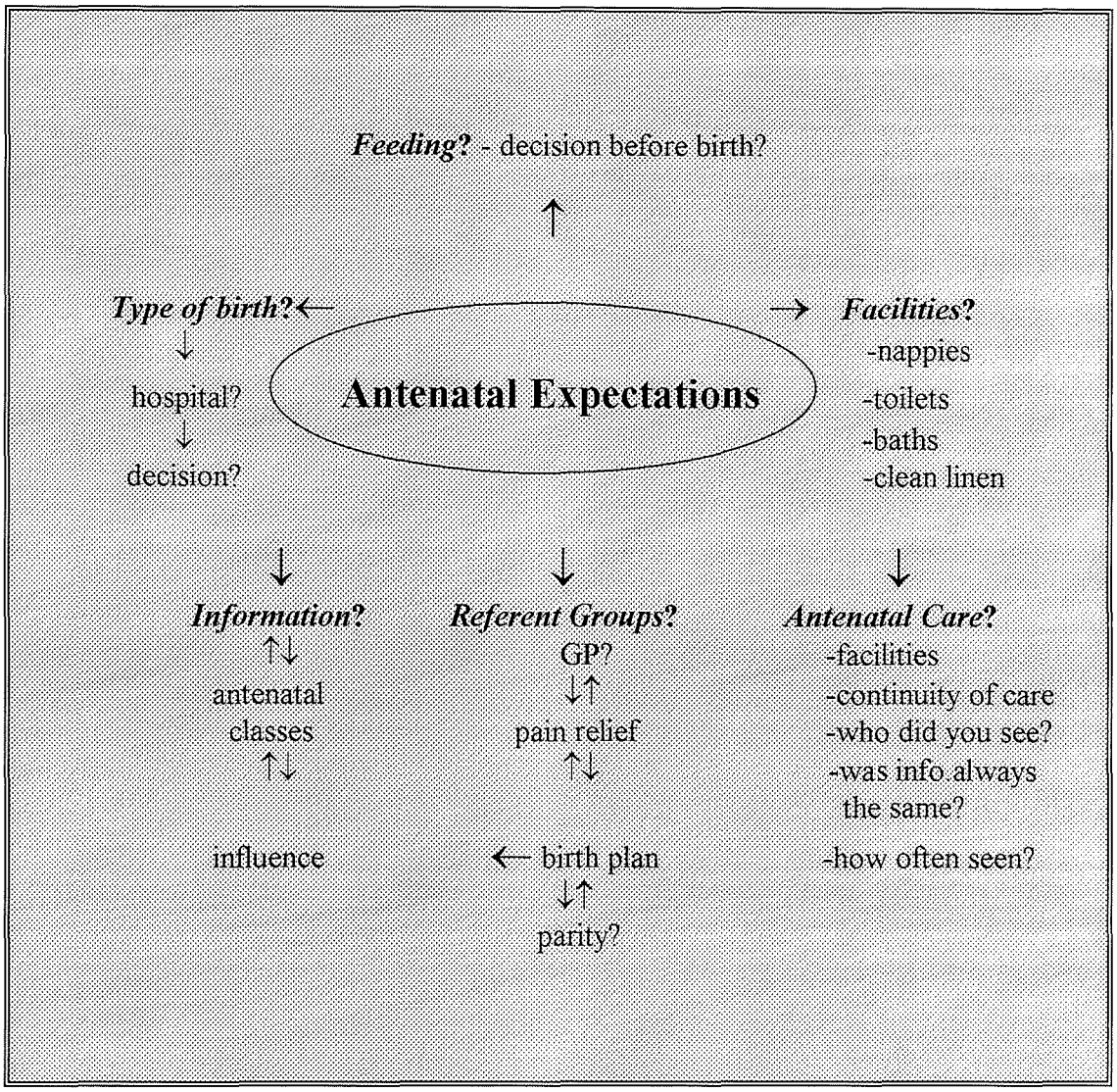
INDEX **13.0 Routine**

INDEX **14.0 Facilities**

Appendix 2

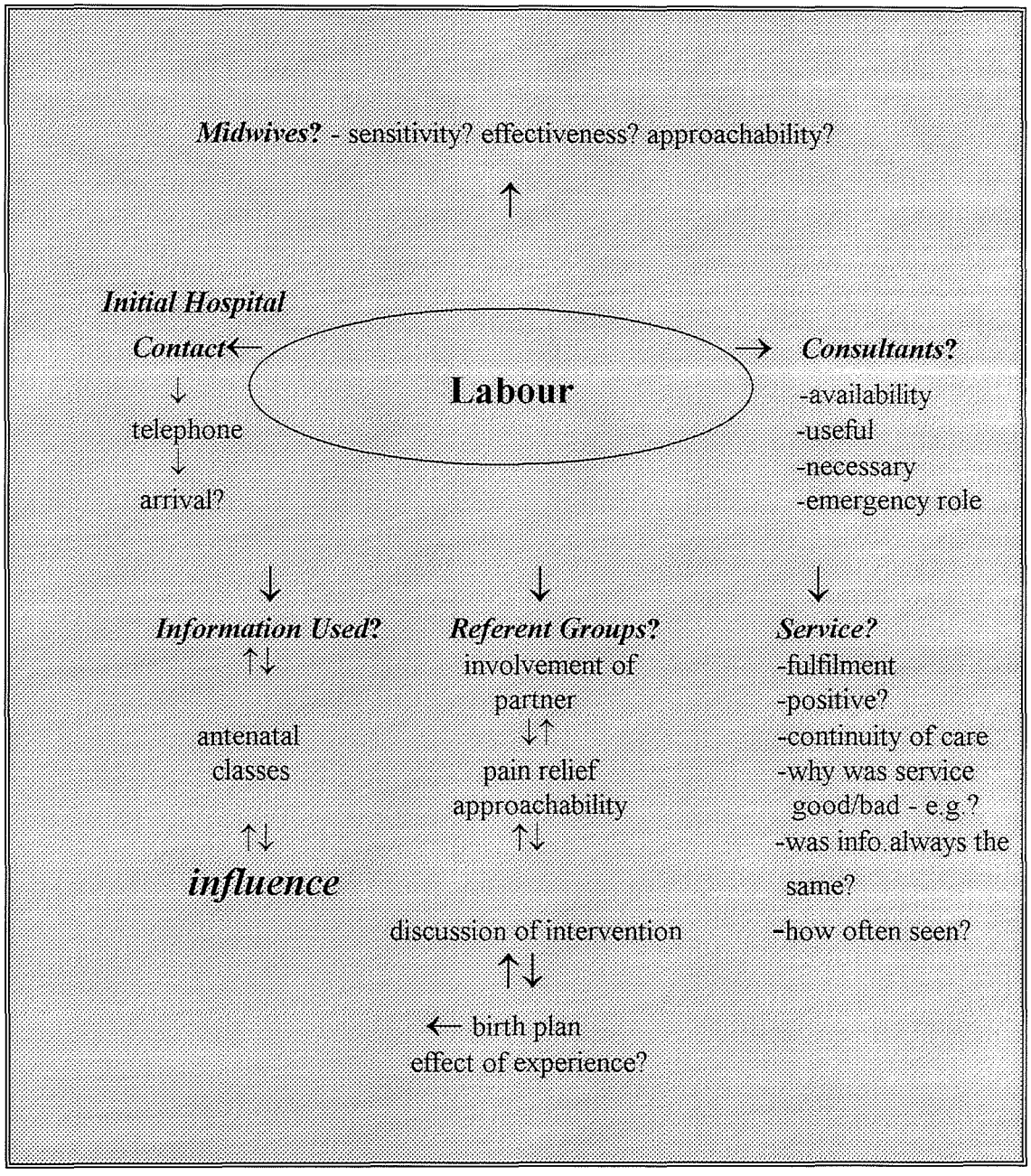
Antenatal Focus Group Format (a)
Labour Focus Group Format (b)
Postnatal Focus Group Format (c)

Focus Group Format



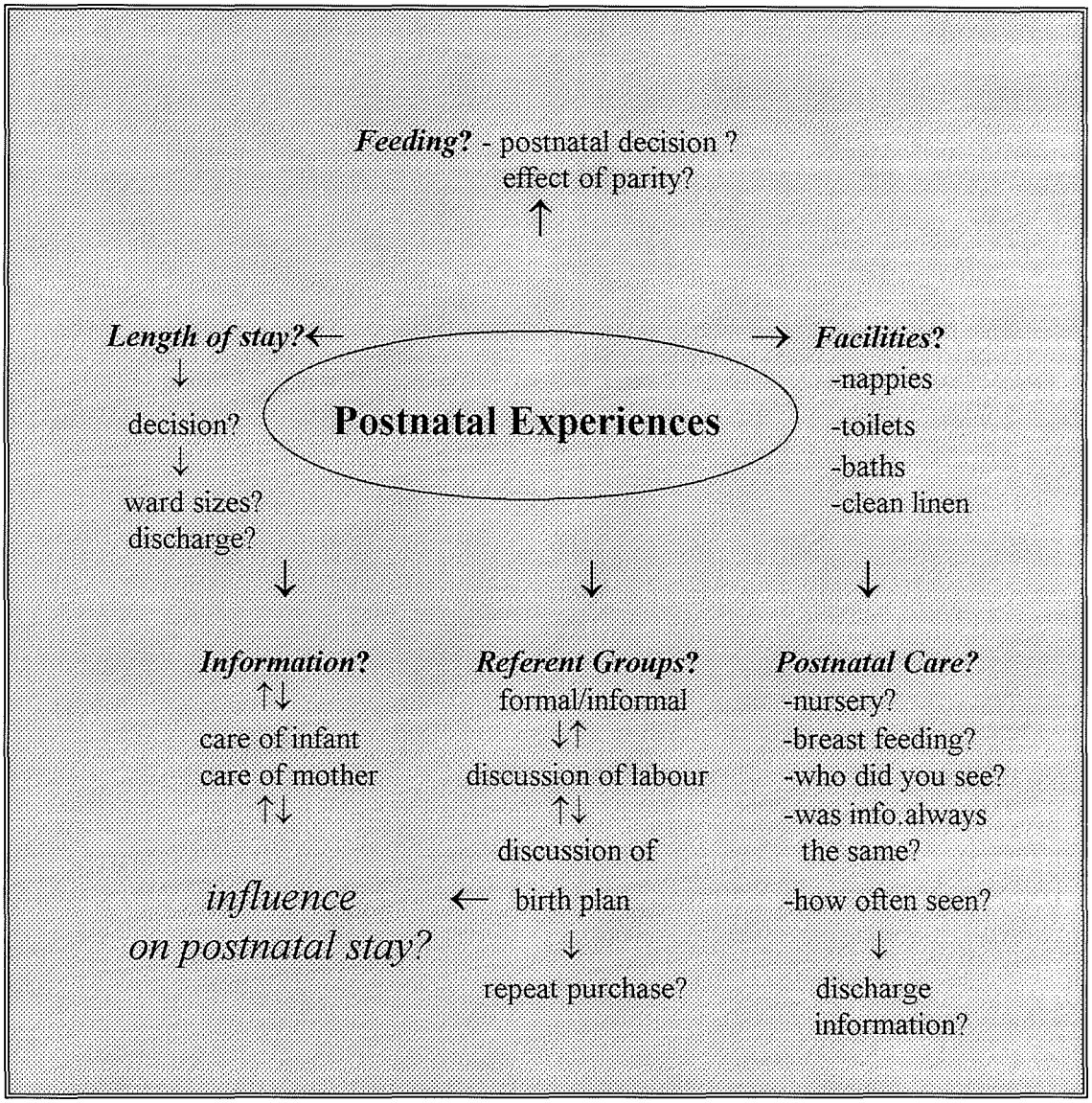
Appendix 2(a): Initial Areas of Focus Group Discussion

Focus Group Format



Appendix 2(b): Secondary Areas of Focus Group Discussion

Focus Group Format



Appendix 2(c):Tertiary Areas of Focus Group Discussion

Appendix 3

Antenatal Interview (a)
Postnatal Interview (b)
Interview Probes (c)

Antenatal Interview

Appendix 3 (a)

1. What is the general opinion of the advice you have received during your pregnancy?

2. What do you think of the information you have read during your pregnancy?

3. How do you feel about the hospital where the baby will be born?

4. What is your opinion of the medical staff who have been giving you antenatal check-ups?

5. How do you feel about waiting for antenatal appointments?

6. What is your general opinion of antenatal classes?

7. What is your general opinion of birth plans?

8. How do you feel about breast feeding?

9. In your opinion, who has given you the best advice during your pregnancy & why?

10. What do you think will be most important to you during labour?

11. What is your general opinion of partners being involved in the pregnancy?

12. What is your general opinion of hospitals?

13. What do you expect the facilities to be like in hospital?

14. What is your overall opinion of medical staff?

15. How do you feel about intervention during labour?

16. How do you feel about being in control of your labour?

17. What is your opinion of having to stay in hospital?

18. How do you feel about safety and security in hospital?

19. What impact, in your opinion, has the Patient's Charter had on the NHS?

Postnatal Interview

Appendix 3 (b)

1. How do you feel about the hospital where your baby/ babies were born?
2. What is your general opinion of birth plans?
3. How do you feel about breast feeding?
4. How did you feel when you realised you needed to go to hospital, in labour?
5. What do you think was most important to you during labour?
6. Who do you think was most important to you during labour?
7. How did you feel about the medical staff during your labour?
8. How do you feel about being left alone during labour?
9. What is your general opinion of partners being involved during the pregnancy?
10. How do you feel about intervention during labour?
11. How do you feel about the facilities in the hospital?
12. How did you feel about staying in hospital?
13. What is your general opinion of the postnatal staff in hospital?
14. How did you feel about the other patients?
15. How did you feel about the food?
16. How did you feel about having the baby in the nursery?
17. What do you think of employee harmony on the wards?
18. How did you feel about the size of the wards?
19. How did you feel about safety and security in hospitals?
20. What impact, in your opinion, has the implementation of the Patients Charter had on the NHS?

Interview Probes

Adapted from Easterby-Smith, Thorpe & Lowe (1991)

Appendix 3 (c)

BASIC PROBE	Repeat Initial Question	(*if wandering off point*)
EXPLANATORY	In what way?	(*for vague statements*)
FOCUSED PROBE	What sort of..?	(*for specific answers*)
SILENT	Pause	(*for slower interviewees*)
DRAWING	More about…	(*if interviewee dries up*)
MIRRORING	Repeat response	(*to amplify answer*)

Appendix 4

Questionnaire

Independent Study of Patients' Views of the Maternity Services

Independent Study of Patients' Views of the Maternity Services
Napier University
Completely Confidential

1. Did you attend the GP surgery for antenatal check ups? yes/no

If "no", go to question 4

2. Who made appointments to see your GP?

   Myself GP Partner

   Other (Please state)_____

3. Upon arriving for appointments, at the GP surgery, was there a maximum waiting time before you were seen?

   yes/no

4. Did you attend the hospital for antenatal check ups?

   yes/no

If "no", go to question 7

5. Who made appointments for the hospital?

   Myself GP Partner

   Other (Please state)_____

6. Upon arriving for hospital appointments, was there a maximum waiting time before you were seen?

   yes/no

7. Have you been in hospital, as a patient, for any ailment in the last four years?

yes/no

8. The Patient's Charter was to allow patients a greater choice and to improve both service and efficiency. Were you aware of the Patient's Charter?

yes/no

If you have only one child please go to question 12

9. *With your second child, did you feel you knew what to expect in terms of available equipment? (Please rate using a scale of 1-6)*

Unclear *1* *2* *3* *4* *5* *6* *Clear*

10. *With your second child, did you feel you knew what to expect in terms of pain relief? (Please rate using a scale of 1-6)*

Unclear *1* *2* *3* *4* *5* *6* *Clear*

11. *With your second child, did you feel you knew what to expect in terms of your own emotional behaviour? (Please rate using a scale of 1-6)*

Unclear *1* *2* *3* *4* *5* *6* *Clear*

12. Considering the individuals listed below, **how useful** was the information that these sources provided before the birth? (Using a scale of 1-6; 1 being not very useful, 6 being very useful and N/A denotes not applicable)

Mother	1 2 3 4 5 6 7 N/A
Sister	1 2 3 4 5 6 7 N/A
Community midwife	1 2 3 4 5 6 7 N/A
Antenatal Classes	1 2 3 4 5 6 7 N/A
GP	1 2 3 4 5 6 7 N/A
Friends with children	1 2 3 4 5 6 7 N/A
Literature (books, leaflets etc.)	1 2 3 4 5 6 7 N/A
Other: (Please state)	1 2 3 4 5 6 7 N/A

13. Was there information you felt you could not obtain? yes/no
If "yes" please state:

_____

_____

14. Please rank the following issues in order of priority: (1 highest priority)

Availability of medical staff 1 / 2
Approachability of medical staff 1 / 2

15. Have you attended antenatal classes? yes/no

16. If you attended antenatal classes, what was the greatest reason?
(*Circle most appropriate answer*)

To hear others' experience To feel involved

To make friends For information

Other: (Please state)_____

17. Did you have enough information upon arriving on the postnatal ward about the following elements? (Please rate on a scale of 1-6, 1 being inadequate information and 6 being full information. N/A denotes not applicable)

Where the nappies were kept	1 2 3 4 5 6	N/A
Where the fresh linen was kept	1 2 3 4 5 6	N/A
Where the bottled milk was kept	1 2 3 4 5 6	N/A
Where the toilets and bathrooms were	1 2 3 4 5 6	N/A

18. Did you expect the hospitals to be clean and well looked after? (Please rate using a scale of 1-6)

Unclean 1 2 3 4 5 6 Very Clean

19. After the birth and after spending time on the postnatal ward, were you satisfied with the cleanliness? (Please rate using a scale of 1-6)

Unsatisfied 1 2 3 4 5 6 Very satisfied

20. How did you expect the food to be? (Please rate using a scale of 1-6)

Unsatisfactory 1 2 3 4 5 6 Very satisfactory

21. After the birth and after spending time on the postnatal ward, were you satisfied with the food? (Please rate using a scale of 1-6)

Unsatisfied 1 2 3 4 5 6 Very satisfied

22. How old are you? (*Circle appropriate answer*)

16-20 21-24 25-28 29-33 34-38 38-42 Other_____

23. Please give your postcode_____

APPENDIX 5

QUESTIONNAIRE ANALYSIS

CONTENTS

Appendix 5.1

Novice and Expert Use of Referent Groups and Literature

(Mann-Whitney U)

Usefulness of Information from Mother:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
90.11	8290.0	92	Experts
80.06	6245.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3164.0	6245.0	-1.3647	.1723

Usefulness of Information from Sister:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
76.68	7054.5	92	Experts
95.90	7480.5	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
2776.5	7054.5	-2.6719	.0075

Usefulness of Information from Community Midwife:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
88.83	8172.5	92	Experts
81.57	6362.5	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3281.5	6362.5	-.9953	.3196

Usefulness of Information from Antenatal Classes:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
94.13	8660.0	92	Experts
75.32	5875.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
2794.0	5875.0	-2.6846	.0073

Usefulness of Information from GP:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
84.83	7804.0	92	Experts
86.29	6731.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3526.0	7804.0	-.1997	.8417

Usefulness of Information from Friends with Children:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
86.75	7981.0	92	Experts
84.03	6554.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3473.0	6554.0	-.3960	.6921

Usefulness of Information from Available Literature:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
86.52	7959.5	92	Experts
84.30	6575.5	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3494.5	6575.5	-.3004	.7639

Appendix 5.2

Novice and Expert Importance of Approachability/Availability of Staff
(Mann-Whitney U)

Approachability of Staff:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
82.80	7618.0	92	Experts
88.68	6917.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3340.0	7618.0	-.8957	.3704

Availability of Staff:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
87.77	8075.0	92	Experts
82.82	6460.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3379.0	6460.0	-.7547	.4504

Appendix 5.3

Novice and Expert Expecatations' and Perceived Levels of Satisfaction Concerning Tangible Aspects of Health Care

(Mann-Whitney U)

Expectation of Cleanliness:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
89.41	8226.0	92	Experts
80.88	6309.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3228.0	6309.0	-1.2339	.2172

Level of Satisfaction:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
84.62	7785.0	92	Experts
86.54	6750.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3507.0	7785.0	-.2640	.7918

Expectation of Food:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
85.29	7846.5	92	Experts
85.75	6688.5	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3568.5	7846.5	-.0626	.9501

Level of Satisfaction:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
81.01	7452.5	92	Experts
90.80	7082.5	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3174.5	7452.5	-1.3319	.1829

Appendix 5.4

Novice and Expert Familiarity with the Hospital Environment

(Mann-Whitney U)

Knew where nappies were kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
84.23	7749.0	92	Experts
87.00	6786.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3471.0	7749.0	-.4054	.6852

Knew where fresh linen was kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
85.09	7828.0	92	Experts
85.99	6707.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3550.0	7828.0	-.1237	.9015

Knew where bottled milk was kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
77.26	7108.0	92	Experts
95.22	7427.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
2830.0	7108.0	-2.5893	.0096

Knew location of bathrooms and toilets:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
83.60	7691.0	92	Experts
87.74	6844.0	78	Novices
			170
U	**W**	**Z**	**2-Tailed P**
3413.0	7691.0	-1.0514	.2931

Appendix 5.5

Higher and Lower ACORN Category Respondents' Use of Referent Groups and Literature

(Mann-Whitney U)

Usefulness of Information from Mother:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
95.38	7630.0	80	Lower ACORN
76.72	6905.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
2810.0	6905.0	-2.5385	.0111

Usefulness of Information from Sister:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
82.95	6636.0	80	Lower ACORN
87.77	7899.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3396.0	6636.0	-.6706	.5025

Usefulness of Information from Community Midwife:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
78.16	6252.5	80	Lower ACORN
92.03	8282.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3012.5	6252.5	-1.9045	.0568

Usefulness of Information from Antenatal Classes:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
105.81	8465.0	80	Lower ACORN
67.44	6070.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
1975.0	6070.0	-5.4852	.0000

Usefulness of Information from GP:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
79.97	6397.5	80	Lower ACORN
90.42	8137.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3157.5	6397.5	-1.4228	.1548

Usefulness of Information from Friends with Children:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
89.35	7148.0	80	Lower ACORN
82.08	7387.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3292.0	7387.0	-1.0588	.2897

Usefulness of Information from Available Literature:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
77.72	6217.5	80	Lower ACORN
92.42	8317.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
2977.5	6217.5	-1.9964	.0459

Appendix 5.6

Higher and Lower ACORN Category Respondents' Expecatations and Perceived Levels of Satisfaction Concerning Tangible Aspects of Health Care
(Mann-Whitney U)

Expectation of Cleanliness:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
80.85	6468.0	80	Lower ACORN
89.63	8067.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3228.0	6468.0	-1.2729	.2030

Level of Satisfaction:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
84.78	6782.5	80	Lower ACORN
86.14	7752.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3542.5	6782.5	-.1871	.8516

Expectation of Food:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
76.61	6129.0	80	Lower ACORN
93.40	8406.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
2889.0	6129.0	-2.2790	.0227

Level of Satisfaction:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
83.54	6683.0	80	Lower ACORN
87.24	7852.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3443.0	6683.0	-.5049	.6136

Appendix 5.7

Higher and Lower ACORN Category Respondents' Familiarity with Hospital Environment

(Mann-Whitney U)

Knew where nappies were kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
86.37	6909.5	80	Lower ACORN
84.73	7625.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3530.5	7625.5	-.2404	.8100

Knew where fresh linen was kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
82.62	6609.5	80	Lower ACORN
88.06	7925.5	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3369.5	6609.5	-.7491	.4538

Knew where bottled milk was kept:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
73.70	5896.0	80	Lower ACORN
95.99	8639.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
2656.0	5896.0	-3.2193	.0013

Knew location of bathrooms and toilets:

MEAN RANK	SUM OF RANKS	CASES	TOTAL CASES
88.71	7097.0	80	Lower ACORN
82.64	7438.0	90	Higher ACORN
			170
U	**W**	**Z**	**2-Tailed P**
3343.0	7438.0	-1.5415	.1232

Appendix 5.8

GP Surgery Waiting Times and Awareness of Patient's Charter

	no	yes	row total
no	70	56	126 79.2
yes	5	28	33 20.8
Column Total	75 47.2	84 52.8	159 100

Chi-Square	Value	DF	Significance
Pearson	17.13131	1	.00003
Continuity Correction	15.54832	1	.00008
Likelihood Ratio	18.72511	1	.00002
Linear-by-Linear Association	17.02357	1	.00004
Fisher's Exact Test:			
One-Tail			.00002
Two-Tail			.00003
Minimum Expected Frequency -	15.566		

Statistic	Value	ASE1	Val/AESO	Approx. Significance
Kendall's Tau-b	.32824	.06475	4.51985	.00001
No. of missing observations: 11				

Appendix 5.9

Hospital Waiting Times and Awareness of Patient's Charter

	no	yes	row total
no	47	57	104 77.0
yes	5	26	31 23.0
Column Total	52 38.5	83 61.5	135 100

Chi-Square	Value	DF	Significance
Pearson	8.51798	1	.00352
Continuity Correction	7.33494	1	.00676
Likelihood Ratio	9.36391	1	.00221
Linear-by-Linear Association	8.45488	1	.00364
Fisher's Exact Test:			
One-Tail			.00249
Two-Tail			.00331
Minimum Expected Frequency -	11.941		

Statistic	Value	ASE1	Val/AESO	Approx. Significance
Kendall's Tau-b	.25119	.07154	3.29509	.00098
No. of missing observations: 35				

Appendix 5.10

Any Treatment in Previous Four Years and Awareness of Patient's Charter

	no	yes	row total
no	53	51	104 77.0
yes	10	21	31 23.0
Column Total	63 46.7	72 53.3	135 100

Chi-Square	Value	DF	Significance
Pearson	3.35661	1	.06694
Continuity Correction	2.64719	1	.10373
Likelihood Ratio	3.42758	1	.06412
Linear-by-Linear Association	3.33174	1	.06795
Fisher's Exact Test:			
One-Tail			.05096
Two-Tail			.09995
Minimum Expected Frequency -	14.467		

Statistic	Value	ASE1	Val/AESO	Approx. Significance
Kendall's Tau-b	.15768	.08240	1.88164	.05989
No. of missing observations: 35				