Satisfaction with obstetric care in the early postnatal period

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ABSTRACT

Introduction: Satisfaction with medical care is defined as the patient's level of acceptance of healthcare, taking into account his or her needs and expectations.
Purpose: Determining the level of satisfaction with care in the early postnatal period. Identification of factors affecting the level of satisfaction with care in the early postnatal period.
Materials and methods: The study covered 100 women aged 15-45, patients of the Obstetrics and Gynecology Department. The study employed the diagnostic survey method, using a custom-designed questionnaire.
Results: 68% of hospitalized patients rated the conditions in the unit as good and very good. According to 42% of them, both the doctors and the midwives provided the patients with exhaustive information and expressed empathy. 54% of the surveyed women had not been acquainted with the floor plan of the unit, and 75% of the personnel had not revealed their names or functions to the patients.
Conclusions: More than a half of the respondents assessed the level of care as good or very good. Assessing the early postnatal care they received, they mostly considered the conditions ensured by the hospital, the level of care from the personnel, both with respect to the women and newborns, and the general atmosphere in the unit.
Key words: Labor, woman, satisfaction with care, medical care

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INTRODUCTION

In the recent years, less than 500,000 children have been born per year, among them 95% born in the maternity units of public healthcare facilities [1].

The aim of healthcare is to provide all pregnant women with early, comprehensive and systematic care, selective with respect to women with increased labor risk. In the last 50 years, radical changes have occurred in Poland in terms of the care for the mother and child. General care for the entire population of women and children has been introduced, including the latest methods of preventive care and treatment in pediatrics and obstetrics, which resulted in a drop in perinatal mortality of fetuses and newborns, and infant mortality, as well as in the pursuit of satisfaction from healthcare services [1].

Midwives taking care of birth-giving women are expected to [2, 3]:

- provide continuous care for the physical and emotional health of the mother and the newborn,
- help develop adequate psychological and emotional reactions of the mother towards the child,
- educate women in labor regarding self-care (hygiene, observation of postpartum discharge and self-inspection of breasts), as well as the identification of early signs of postpartum pathologies,
- promote breastfeeding (support and comprehensive education),
- take care of the emotional health of the family,
- instruct the childbearing women regarding pelvic floor muscle exercises,
- motivate to a healthy lifestyle,
- evaluate and ensure a proper form and quality of social support for the family.

Satisfaction with medical care, also in maternity units, is defined as the patient's level of acceptance of healthcare, taking into account his or her needs and expectations. It constitutes one of the central human values and generally refers to satisfaction with life, well-being, sense of happiness, good mood, or quality of life [4].

Some researchers [4] consider satisfaction with life in three dimensions: cognitive assessment, presence of positive effects and absence of negative effects.

A patient's satisfaction is an important component of healthcare quality assessment [4]. Medical care is a factor determining the overall patient satisfaction, mostly influenced by the behavior and mutual interactions of the medical team. Patient care should be provided 24 hours a day, recognizing their demands and expectations [4].

Definitions of the term "satisfaction with care" found in the literature differ in content and the level of generality: from the lack of interest and negligence of care to satisfaction with life in general [5]. The sense of satisfaction is a psychological phenomenon, a subjective feeling of pleasure and contentment, manifested in the form of significant features (reactions, behaviors, attitudes). The level of human satisfaction covers a certain range of values from-to (complete lack of understanding – complete satisfaction). According to Dozier et al. [6], although the level of satisfaction is presented in a linear manner, the aspects of care that significantly affect the increase in this level may (but do not have to) be completely different from the ones causing a patient's dissatisfaction with care. In such case, "satisfaction" and "its lack" should be positioned on two independent continua instead of on the opposite sides of the same continuum.

The quality of medical care may be evaluated from the point of view of the service provider – a doctor, nurse and other staff – or the service recipient – patient or client [7]. The quality of care, as viewed by the patient, may be assessed by studying his or her satisfaction.

Patients expect nurses and doctors to satisfy their health needs, and the availability and qualifications of the medical personnel constitute the major elements of service quality, emphasized both by healthcare managers and patients [8]. Patients also add other quality yardsticks, such as "acceptance of care" expressing the compliance of the care provided with the patient's preferences, and "politeness of care", referring to the level of discretion and comfort. Satisfaction with care is also strongly determined by the personnel's attitude towards the patient and attention to his or her problems ("quality of personnel behavior") [8].

The patient has the right to expect that services received in the hospital correspond to the requirements of the current medical knowledge, and the quality of care offered by a given facility is adequate and high [9].

The quality of nursing/maternity care felt and perceived by the patient is the indicator of evaluation of the overall care provided in a given healthcare facility, and it should be determined using qualitative research methods, the features of "good caretaking" important to the patient population under study [10].

As recommended by WHO [11], non-medical aspects of care should also be monitored, including:

- trust, honesty, credibility;
- personnel's respect for the patient's dignity;
- independence (the right for information about the illness and alternative treatment methods, etc.);

- secrecy (protection of the patient's personal information);
- satisfaction with medical care;
- availability (help in emergencies, surgical help when needed, relatively short waiting time before examination, consultation, registration, etc.);
- reliability (on the part of professional employees);
- access to psychological and social support during treatment (visits from the family and friends, the possibility of exercising religious practices, etc.);
- the choice of the service provider;
- accommodation [11].

Market research [12, 13] confirms that quality, as determined from the patient's/client's perspective, is composed of elements often being unrelated to the medical service itself, such as competence, manners, quickness of reaction, diversity, or reliability, as these factors are most visible for the patient.

The aim of this study was to determine the level of satisfaction with care in the early postnatal period, and to identify its determinants.

MATERIALS AND METHODS

The study included 100 women, patients of the Obstetrics and Gynecology Unit of the Province Hospital in Łomża, upon prior consent of the Hospital management and the respondents. The study was conducted between November 2012 and February 2013, and employed a custom-designed, anonymous questionnaire. Before being included in the studied group, the respondents were informed about the purpose and anonymous character of the study. Upon giving consent for participation, the participants completed a questionnaire composed of 32 questions, regarding their satisfaction with early postnatal care. The questions referred to the evaluation of the medical services provided during labor and afterwards, information about the course of pregnancy, patients' expectations about room equipment, child care, and the availability of contact between the woman in labor and her family.

RESULTS

The studied group included 100 women, aged 31-35 (29%), 21-25 (25%), 26-30 (22%), 15-20 (14%), 36-40 (6%), and 41-45 years (4%).

Eighty-four percent of the respondents were married and 16% were single.

A total of 49% of the surveyed women lived in cities with populations over 50,000; 22% were patients in cities and towns with a population under 50,000; 15% were in towns with a population under 5,000; and the remaining 14% were countryside-dwellers.

As far as education is concerned, the majority of the women (52%) had graduated from general secondary schools. Only 8% of the respondents were vocational school graduates, and 5% had elementary education. Respondents with a BA-level education accounted for 20% of the surveyed group, and 15% of the participants were MA degree holders.

The distribution of the respondents' professional status was quite homogenous. The majority of the surveyed women (35%) performed both manual and non-manual work, 33 patients (33%) declared themselves as blue-collar workers, and the remaining 32% were white-collar employees.

Regarding pregnancy ending in labor, the great majority of women (81%) said their pregnancy followed a regular course. Only 6% declared an irregular course, and the remaining 13% said they had experienced problems during pregnancy. As many as 7 out of the 13 women whose pregnancies were problematic (53.9%) complained about contractions in the first trimester, one (7.7%) had had high blood pressure, and another one (7.7%) reported a breech position of the baby. Moreover, three women (23.1%) struggled with distressing bleeding and one (7.7%) said her biggest problem was nausea and headaches.

The vast majority of the respondents (n=97) declared they had been using gynecological and obstetrical care throughout their pregnancies.

A total of 65% of respondents complained about various ailments, including: heartburn (n=21, 32.3%), nausea (n=20, 30.8%), elevated blood pressure (n=7, 10.8%), abdominal pain (n=6, 9.2%), back pain (n=6, 9.2%), disturbing contractions (n=2, 3.1%), and the remaining three women (4.6%) listed swelling, oversensitivity and hip pain.

The patients' decisions regarding the presence of third parties during labor were quite evenly distributed: 49% were accompanied by their relatives (husband, mother or sister), while 51% only allowed the presence of medical personnel.

The respondents were asked to rate from 1 to 5 (with 1 corresponding to bad and 5 to very good) the conditions in the unit, taking into account the equipment, tidiness, and temperature in the rooms. The opinions on this matter varied considerably: 2 women (2%) found the conditions bad, another 2 (2%) – poor and 28 respondents (28%) decided they were satisfactory. More than half of the surveyed group (54%) declared the conditions were good, and 14% assessed them as very good.

The activities of personnel that determine the satisfaction with care include acquainting the patients with the floor plan of the unit they are staying at, and informing them about their rights,

health status and procedures performed. Sadly, only 46% of women form the surveyed group received information about the unit's floor plan.

As far as patient-related information is concerned, we specified if it was obtained from a midwife or a doctor. A total of 42% of women (42%) said the information provided by midwives were exhaustive and comprehensible, and the personnel displayed empathy. Unfortunately, 30 respondents (30%) felt they were under-informed, and another 28 women (28%) believed the information they had received was incomplete or presented in a confusing language. The respondents' opinions with regard to the information provided by doctors were similar. According to 42 women (42%), the level and manner of providing information was very good and the doctors' attitude was friendly. Dissatisfaction with this aspect was expressed by 26 women (26%), who thought the information they had received had not always been complete, as well as by another 32 respondents (32%), who also complained about the obscure language used by the doctors.

The responses regarding information about the medical services performed and the related procedures were as follows: 47 (47%) patients believed they had been informed exhaustively, 36 (36%) said the information about procedures was far from satisfactory, as it was incomplete and incomprehensible, and the remaining 17% of respondents declared they had not received such information at all. As many as 66 women (66%) have not been informed about their rights as patients.

We also inquired about the time the patients had to wait for the arrival of a midwife called via an alarm bell, or a doctor they asked for help. The highest number of the respondents (n=44, 44%) had waited for the midwife 3 to 5 minutes, 26 women (26%) – 6 to 10 minutes, and 16 women (16%) had only waited under a minute. The longest waiting times were 11-30 minutes (n=8, 8%) and 31 minutes to 1 hour (n=6, 6%). As regards doctors' arrivals, the waiting times were as follows: 28 women (28%) had waited 6 to 10 minutes Only 6 respondents (6%) obtained medical helps within a minute from asking.

The survey revealed that 5 respondents (5%) had not received help from the medical personnel, either from a doctor (n=2) or from a midwife (n=3).

The respondents pointed out that in 75% of cases, the personnel they had encountered at the hospital had not introduced themselves in terms of name and function.

Only 75% of the respondents felt the personnel cared for the patients' sense of dignity and intimacy during the medical procedures performed.

Regarding the personnel's attitude towards visiting families, 80% of women decided the midwives and nurses had been friendly, and 68% of women said the same about the doctors.

Moreover, the respondents were asked to assess their satisfaction with the care they received after giving birth. A total of 55 (55%) patients had evaluated it positively: 25 women (25%) thought the postnatal care was very good, and 30 (30%) decided it was good. Furthermore, 39 patients (39%) viewed the care as satisfactory. However, 6 women (6%) had a negative impression about the care: 4 of them assessed it as poor, and 2 as bad.

With respect to the satisfaction with the care provided for the respondents' newborns, 5 (5%) women thought its level was low (1% - bad, 4% - poor), and the rest felt it was satisfactory (30%), good (50%) or very good (15%). Moreover, 58% of the participants decided the amount of time the midwives devoted to mothers and their children was sufficient, and 42% thought the same about the doctors.

Many of the patients (68%) would recommend the hospital they had given birth at to their family and friends, the reasons being good conditions (19%), good care provided by the personnel (33%), and pleasant and peaceful atmosphere (16%). The remaining women would not recommend the hospital due to poor conditions (9%) and poor medical care (23%).

DISCUSSION

Measurement of patients' satisfaction with the obtained medical services is a requirement imposed on Polish healthcare facilities by units representing hospitals, and the level of the patients' satisfaction is considered as one of the indicators of the overall quality of care offered by healthcare facilities [14]. The importance of activities aimed at improving patients' satisfaction with care results from the fact that a satisfied patient behaves differently than a dissatisfied one. A dissatisfied patient does not follow the recommendations offered by the doctor or nurse, ends treatment prematurely, does not cooperate in the implementation of the care and treatment plan, and seeks help elsewhere [14]. In contrast, a patient who is satisfied with care, is loyal to the service provider and will use the services of the same healthcare facility if necessary. Moreover, he or she will also recommend the facility to other customers. Finally, he or she will most likely get better results of the treatment [11, 15]. Service providers that guarantee high-quality care, assessed exclusively on the basis of objective indicators, and measurement of patient satisfaction, achieve great economic benefits through increasing their cost-efficiency and ensuring prospective clients "who bring in more

money" – thus improving their competitiveness on the healthcare service market [16].

A number of definitions of "patient satisfaction" were published in literature. Yellen [17**]** presented a definition adopted by the American Nurses Association. It defines patient satisfaction as *"the measure of the patient's or family's opinion about the obtained nursing care".* Wilkin et al. [cit. after 18] described patient satisfaction as *"the complete satisfaction of expectations or needs"* and *"the complete securing of expectations or needs"*.

Pascoe [19] defined patient satisfaction as *"a comparative process involving the service recipient's cognitive and emotional reactions to important aspects of his or her experiences concerning the structure, process and outcome of care".* The definition recognized and adopted in the nurses' circles is the one given by Risser [cit. after 20], stating that *"a patient's satisfaction with nursing care is the effect of comparison of the degree to which the patient's expectations about the services and nursing care agreed with the perception of the actually received care".* Patient satisfaction is the outcome of the perceived and expected quality of medical care [21]. A similar conclusion was reached by Mykowska [22], who stated that *"patient satisfaction depends on the difference between what they receive and their subjective expectations; if the difference is positive, the patient is satisfied, if negative – the patient is dissatisfied"*.

The period of pregnancy and labor is the time when medical care should be particularly satisfactory. Apart from scheduled gynecological visits, the woman has the right to consult her doctor in case of any emergency or any time she feels anxious. The standard schedule includes an examination every 4 weeks, on average. The schedule prepared by the doctor should be followed, even in the case of uncomplicated pregnancy. The check-up visits are aimed at minimizing any potential complications of pregnancy, as well as at early detection of any irregularities [23]. The proper care during pregnancy is based on the woman's trust in her gynecologist, who undertook such duty. According to a 2009 CBOS study, 90% of respondents declared they trusted their doctors [24].

Nearly all our participants were under regular medical care. As many as 65% of the pregnant women reported pregnancy-related ailments such as abdominal pains, nausea, heartburn or swelling. The adequate and thorough care of the pregnant women resulted in 76% of the respondents being hospitalized during their pregnancies. Presumably, the reasons for which the attending doctors had made such decisions were important for the mothers' and child's safety.

The support offered during the labor itself is one of the factors that were recognized and confirmed in many international studies as affecting the satisfaction of women [25]. The hospital stay is a difficult situation evoking a feeling of loneliness, uncertainty, isolation and fear about one's own health and the well-being of the unborn child. These feelings are further enhanced by the necessity of being subjected to unknown medical procedures, sometimes without prior exact knowledge of their essence, the inability to behave in a new situation, and the disturbance of personal security. The stress accompanying hospitalization negatively affects the course of childbirth. The emotions experienced by the woman, either positive or negative, may significantly influence the labor process, prompting or hindering the latter [26].

According to WHO recommendations, the birth should take place in the company of the child's father or another close relative of the mother [27, 28]. This thesis was confirmed by Kraśnianin et al. [26], who showed that over a half of Polish (52%) and nearly all German (99%) respondents were accompanied by someone close, usually the husband or partner. All respondents, both from Poland and Germany, admitted the hospitals they stayed in made it possible for their close ones to both visit them and be present during labor [26].

These findings are consistent with the results of our study, as almost a half of our participants (49%) gave birth in the company of the closest family, most often their husbands.

Childbirth is not just a medical condition, but most of all an event with huge importance for the woman's psyche and identity, an immense emotional experience, and a family event. Its quality is determined not only by the act of labor itself, but also by what proceeds and follows it. The majority of the surveyed women assessed the conditions at the unit as good (54%) or very good (14%). Less than half of them (46%) have been acquainted with the unit floor plan upon being admitted.

The joint stay of the mother and child during hospitalization was a standard in both hospitals studied by Kraśnianin et al. [26]. Both Polish and German patients complained mostly about insufficient assistance and instruction in child care [26].

In modern obstetrics, a great emphasis is put on the direct contact between the mother and child after labor, and active assistance of the medical personnel in having the baby breastfed and solving problems with care and feeding. Only 32% of our respondents were not disappointed by the personnel in this aspect. Half of them claimed it depended on the specific personnel on duty. Most surveyed women (44%) reported they had waited for the midwife's help 3 to 5 minutes. Sadly, in some cases (6%) women waited as long as 31 to 60 minutes. As far as doctors are concerned, the largest group of respondents (28%) waited up to

10 minutes for the doctor's arrival; the others had to wait less than 30 minutes (26%) or less than 1 hour (16%).

Section 14 of the Physician's and Dentist's Profession Act, and Section 14 of the Code of Medical Ethics specify the physician's informative duty. It is an autonomous duty, independent of other physician's duties towards the patient. It is the physician's responsibility to provide the patient with comprehensible information about their health, diagnosis, suggested and possible diagnostic and treatment methods, the predictable consequences of their application or lack thereof, the results of treatment and prognosis. Moreover, the physician must respect the patient's right for conscious participation in making decisions about his or her own health. These abovementioned regulations comply with the Council of Europe Convention on Human Rights and Biomedicine, which states in Section 10(2) that every person has the right to be acquainted with any information collected about his or her health [29].

A total of 48% of respondents participating in the Polish national survey conducted by CBOS in 2001 [30] complained they had not been treated equally in healthcare facilities, and that they had not experienced kindness and care from the personnel. 17% of the patients declared they had not been fully informed about their health and treatment process, and 9% said the information they received was incomprehensible.

According to 42% of women surveyed in our study, midwives (and physicians, in the opinion of the same percentage of respondents) provided exhaustive and comprehensible answers to the questions they were asked, and displayed empathy in personal contacts. Regarding information about the medical services provided, 47% of respondents were informed exhaustively, while 36% claimed the information about the procedures performed was far from satisfactory, namely incomplete and incomprehensible.

Unfortunately, most women (66%) were not informed about their rights as patients. Moreover, only 10% of the personnel introduced themselves to the patients, providing their names or functions. Undoubtedly, such situation may have resulted in disturbed contacts between the patient and personnel, and in the disruption of the patient's sense of security, and, consequently, in the lower perception of the quality of the medical services received.

According to respondents involved in the research conducted by Jóźwik et al. [31], doctors treated their patients subjectively. As many as 62% of patients said their dignity was respected very well; 30% of participants declared that their dignity was respected well, and 6% assessed this aspect as average.

The vast majority of women (75%) participating in our study admitted the personnel had respected their dignity and intimacy during medical activities or examinations.

Importantly, 55% of the respondents described their satisfaction with care as very high or high, and 39% thought it was satisfactory. As far as satisfaction with care for the newborn is concerned, 65% of the surveyed mothers were very highly or highly satisfied in this matter. Such positive assessment was reflected by the declaration of 68% of the patients that they would recommend the facility to other pregnant women among their family and friends.

Based on the results of our study and previous research [24,30,32], one may notice that patient's rights are still viewed as an addition to proper healthcare, rather than as its vital component. Lack of respect for a woman's right for information and informed voluntary consent for medical interventions, frequent infringement of her intimacy and dignity, and charging her for "nonstandard services" enhances the subordinate status of the patient to the institution of the hospital, and to its personnel. In most facilities, the patient's right for self-determination, though guaranteed by the Constitution of the Republic of Poland and numerous acts of law, is not reflected in the procedures or standards of behavior towards women in labor and their children [24,30,32].

CONCLUSIONS

1. More than a half of the respondents assessed their satisfaction with the care as good or very good.
2. In assessing the early postnatal care they received, the respondents mostly considered the conditions ensured by the hospital, the level of care from the personnel, both with respect to the women and newborns, and the general atmosphere in the unit.

Conflicts of interest

The authors declared no conflicts of interest.

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