Author's response to reviews

Title: Women's experience of maternity care services

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Author's response to reviews: see over
Cover letter to BMC

Dear Editors,

In response to your e-mail of September 22 with the comments of the three reviewers I hereby send you the revised manuscript. In this letter I will give a point-to-point response to the concerns of the reviewers. First of all, I am very pleased with the constructive comments. They really helped me to improve and rephrase the text at several points.

Furthermore, the revision includes:
1) more context information in the Background section of the abstract;
2) more detailed information in the Method section of the abstract;
3) a declaration in the CI section about the insurance companies that funded this study.

Because I am the sole author of this manuscript I could not comply with your request to include an Authors’ contribution. Together with the funding agency (Miletus, a consortium of (then) four insurance companies) and based on earlier research on CQI development I personally designed the study, performed the statistical analyses and wrote the manuscript. Data were collected by an external party, a mailhouse.

Reply to reviewer 1:
1. Title and abstract:
I changed the title, but I did not include ‘satisfaction’ as this manuscript is not about satisfaction, but about quality of care from the clients’ perspective. The difference is small but distinct: in satisfaction studies the focus is on the client, who is or is not satisfied. In quality of care studies the focus is on the care provider. This new instrument, the CQI, is focused on the care: what is the quality of the care as experienced by clients.
I expanded the Background and Methods sections of the abstract.

3. Methods:
The sample is drawn from the lists of four large insurance companies, each with the majority of their clients in different parts of the country.
Composite measures were constructed using factor analysis, followed by reliability analysis. The number of items in each composite measure is added to the text.
More information on this development in reference 18 (in Dutch).

5. Discussion/Conclusions:
The discussion about continuity of care and of carer differs in the Netherlands from that in, for instance, the UK, where often antenatal care is provided by one caregiver and care during labor and birth by another. Thus, continuity of carer is in most countries not what is expected, except in the Netherlands. Referral shortly before or during labor into the hands of an unknown care provider (gynecologist or hospital midwife) or the presence of an unknown midwife, because the familiar midwife is not available, is often experienced as a disappointment.
The question whether referrals lower the evaluations can not be answered., because the care the women received after referral (secondary care) was different from the care they received before referral (primary care). I did find that women giving birth in secondary care scored lower (3.64) than women giving birth in primary care (3.87) (see under: results, p.8).
However, in earlier research with a Dutch population it was shown that an unplanned transfer to hospital did not influence the birth experience of women who had planned to give birth at home. Neither did it influence their evaluation of the birth, the midwife or the postpartum period [1].
‘The influence of deviations ..’ was not correct. What I meant was: ‘The differences in quality as experienced by the women were related to the differences in care setting and not influenced by parity.’
I agree with the reviewer that the paper may benefit from more references, but too many references about satisfaction with childbirth would put the reader on the wrong track, because this paper is not about satisfaction but about quality of care.
There are no consequences for the Dutch gatekeeper system and the practice of health professionals resulting from this study. As far as maternity care is concerned, care for normal pregnancy and childbirth is not a task for gynecologists.

Language comments are acknowledged.

A graphical representation of the care path is added. I hope this will help.

Tables and figures:
Table 3: Indeed, one in three nulliparae planned to give birth in hospital with their own midwife (in primary care), but two in three ended up giving birth in secondary care. This is the result of two interdependent variables. First of all, nulliparous women, much more often than parous women, prefer to give birth in hospital. Second, nulliparous women are much more often than parous women referred to secondary care during labor (because they have no ‘obstetric history’ there is seldom reason to refer them before the onset of labor).

The relatively high referral rate of nulliparous women is not a new finding but a well known fact and women may anticipate on it by choosing to give birth in hospital [2].

Table 4: There are statistics based on PRN data (The Netherlands Perinatal Registry), but these are somewhat biased, because the births assisted by general practitioners are not included. PRN data for 2006 are: 15.1% CS, 9.7% assisted delivery (vacuum or forceps) 75.1% spontaneous birth (including induction, augmentation, AROM) [3]. The national data from the Central Bureau of Statistics (CBS) are data about the CS rate (13.6 per 1000 births in 2003). Adding these data will be more confusing than helpful.

Reply to reviewer 2:

1. Background:
Language comments (i) and (ii) are acknowledged.
Language comment (iii): in the Netherlands a midwife is a medical practitioner, just like a GP or a gynaecologist, but with a limited professional competence. Therefore the midwife is sometimes referred to as the ‘medical specialist in normal childbirth’. But I understand this can cause confusion. I have changed it.

2. Methods:
There were identifiers to link the antenatal and postnatal surveys.
Denominators are added to response rates.
Within the context of maternity care the terms ‘gynecological’ and ‘obstetrical’ are seen as interchangeable in the Netherlands. But it is not my intention to create confusion and as ‘gynecology’ is the term most often used in the Netherlands for maternity care provided by a medical specialist, I prefer to use that in this paper as well. The term ‘obstetrician’ was used once in the text (background), and only in combination with the term ‘gynecologist’. In the conclusion secondary (obstetrical) care is mentioned. That is changed in secondary (medical specialist) care.

3. Results:
Tables are corrected
Table 3: only birth in hospital with a gynecologist is birth in secondary care. The others are primary care or unknown. The information is added.

4. Abstract:
Abstract is adapted.

5. Background:
NIVEL and QUOTE have been defined.
This paper refers to research that was done within the framework of developing an CQI Maternity Care. It is not about the CQI. Therefore I removed a number of unnecessary references to CQI instruments in general. But it is necessary to mention the developments leading to the CQI to show that this is not a survey about satisfaction with childbirth, but about the quality of maternity care. That also explains why there are not many references, especially not about satisfaction.

6. Methods:
Composite measures are constructed with factor analysis and reliability analysis. To explain them I included the items of the composite measure for treatment and removed reference to other composite measures.
The data for this paper were collected within the framework of a development and validation study. The Cronbach’s alphas are reported in the study report on which this paper is based (see reference 18).

7. Results:
Table 6 is replaced with a new table as well as a figure. New table 6 contains the information from the last two paragraphs of the result section, Figure 2 contains part of the information from the old table 6. Number of events are added where appropriate, p-values are explained, the 126.5% is explained. Significance in table 3: planned and actual place by parity. Numbers in text and table differ as result of missing values when cross tabulating with parity.

9. Conclusions
Reliability is mentioned in the methods section. Missing responses occur on each item. Where appropriate the number of responses is added in the tables. Because this is not about satisfaction with childbirth, or with health care, but about quality of care from the client’s perspective, there is not much literature to refer to.

Reply to reviewer 3:
The reviewer is correct in suggesting that there are actually two questions in this paper, but it is not possible to disentangle the two subjects completely. To improve the readability I have reduced the information about the CQI, especially about the instrument development. But I need to clarify that this project was about quality of care (with focus on the care provider), not about client satisfaction (with focus on the client), therefore, I need to explain the instrument that was used: the CQI. As suggested I added more information about maternity care in the Netherlands to the introduction, but comparison with earlier research is difficult because there are no (recent) reliable data regarding the use of maternity care. The information about the number of ultrasound scans is new and can not be compared with earlier findings from a comparable study population. As suggested, in the discussion the focus is now more on the care path and the differences with other countries, than on the CQI. Composite scores are explained. Seeing a gynecologist more than once (table 1) is the same as having regular check-ups (as opposed to incidental contact) with the gynecologist. More information and referrals are given about maternity care in the Netherlands. Discussion is adjusted.

