Personal maternal care reflections of general practice physicians

Anna MacKenzie and Lesley Roberts*

Primary Care Clinical Sciences, School of Health and Population Sciences, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK.
*Correspondence to Lesley Roberts, Primary Care Clinical Sciences, School of Health and Population Sciences, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK; Email: l.m.roberts@bham.ac.uk
Received 23 March 2011; Revised 14 July 2011; Accepted 23 July 2011.

Background. As the number of female GPs increases, the need to understand delivery of maternity care to this group becomes increasingly important. Previous literature suggests doctors face additional barriers in utilizing health care compared to other patients, but little is known about GPs’ maternal health care experiences and whether their occupation facilitates or compromises care.

Objective. To explore female GPs’ personal experiences of maternal health care and how occupation affects care received.

Methods. Female GPs with children aged 6 months to 5 years were recruited from South Birmingham Primary Care Trust with subsequent snowballing. Data were obtained using semi-structured interviews and constant comparison analysis was applied to develop themes and categories.

Results. Fourteen GPs participated and no new themes emerged after interview 10 suggesting data saturation was achieved. Overall, GPs felt they received better care due to their occupation and where established relationships between the GP and the health care professional existed, communication and care satisfaction was enhanced. However, assumptions about knowledge led to reduced information provision and some problems in care provision, especially during labour and early motherhood when women were most vulnerable and unable to rely on work skills to address information deficits.

Conclusion. This research supports the growing body of evidence that there are unique problems facing doctor–patients and clinicians treating them. However, contrary to expectations derived from anecdotal evidence, GPs indicated that care was enhanced due to their occupation. This study raises awareness of areas for consideration when female GPs approach pregnancy and health care professionals deliver maternal health care.

Keywords. Doctor–patients, general practitioners, interview, maternal health services, qualitative research.

Introduction

As the number of female physicians increases, so does absolute numbers of physicians experiencing pregnancy.1–5 In 1994, 37% of GP registrars were female and by 2004, this had increased to 60%.3 The few publications studying pregnancy in doctors focus only on pregnancy outcomes or workplace experiences.6–13 Current evidence about doctor–patients’ health care experiences is limited to recognizing their health care barriers but with insufficient understanding of their causes.13–18 Literature acknowledges difficulties managing doctor–patients for reasons including: difficulties adopting a patient role;19,20 the treating doctor feeling intimidated and judged,21 communication problems due to balancing assumptions about what the doctor–patient knows to ensure sufficient information is delivered without being condescending and the doctor–patient feeling embarrassed asking simple questions.16 Research suggests doctor–patients expect to be treated as other patients but are often not.16,22–24 Physicians do not get specific training on how to treat doctor–patients.21 Given that doctors can experience difficulties treating doctor–patients, it could be hypothesized that this is magnified for midwives or other non-doctor health care professionals (HCPs) due to historical hierarchy issues.

GP training involves some obstetrics care; but once qualified, the involvement in maternal cases decreases substantially with midwives providing the majority of care in the UK, thus limiting GPs’ experience in this area.25 Despite this, GPs as family doctors may be perceived as being knowledgeable about both pregnancy and post-natal care, making them different to other specialties.26 Even with good clinical knowledge and experience, this may not adequately prepare female
GPs to become the patient and they may be at risk of reduced support and care in pregnancy, which may impact on the health of both the mother and baby or result in a poor pregnancy experience.

This article presents findings from a qualitative pilot study, exploring GPs’ personal experiences of maternal health care and their perceptions on how their occupation impacted on this.

Methods

Research design
Given limited evidence and the exploratory nature of the study, qualitative, semi-structured, one-to-one interviews with GPs were considered to be the most appropriate means to investigate what was anticipated to be a complex topic. Since no other studies have researched this topic, pilot exploration of core themes relating to female GPs’ experiences of pregnancy care was undertaken.

Participants
A convenience sampling strategy was employed to recruit eligible GPs. All practices within South Birmingham Primary Care Trust, who are members of the Midlands Research Consortium (MidReC), were contacted initially, with snowballing beyond this sample to obtain further participants, all within the UK. Those interviewed were invited to pass information onto suitable colleagues. An information letter was sent to Practice Managers outlining the study, asking them to pass information sheets and response forms to GPs of any status, including locums and part-time staff, who met the inclusion criteria. To reduce recall bias only GPs having given birth in the last 5 years were eligible for inclusion. A lower limit of 6 months was applied to ensure that all participants had received the full range of antenatal and post-natal care. GPs with serious adverse pregnancy outcomes were excluded to minimize potential distress to participants. The 14 GPs returning response forms were contacted to arrange an interview at their convenience: 5 at the GP’s practice, 3 at the GPs’ homes, 2 at the University of Birmingham and 4 telephone interviews. Table 1 describes participant demographics.

Data collection
Semi-structured interviews were conducted by a single female researcher (AM), studying medicine, with no personal experience of childbirth. Interviews lasted between 16 and 57 minutes and were conducted between March 2010 and April 2010. Interviews were open-ended and conversational in style. The researcher followed a topic guide developed following review of the literature, discussion between researchers and pilot interviews (not included in this sample). Five areas were explored: demographics and clinical experience; experiences of antenatal care; intra-partum care; post-partum care and consideration of how occupation acted as a barrier or facilitated care. Open questions elicited free responses. If necessary, more focused prompts were used to encourage exploration of the main questions. Modifications were made in light of emerging themes. Prior to interviews informed written consent was obtained from all participants. All interviews were audio-recorded, field notes were made during and immediately after interviews and anonymized by application of a unique reference number.

Data analysis
Interviews were transcribed verbatim and these formed the basis of constant comparison analysis. This was a systematic evolving process using data-driven coding, alongside interviews. Each transcript was initially read without comment. Once familiarized with the data, NVivo (version 8.0) facilitated data coding and organization into conceptual themes and categories related to research aims. Comparisons of themes both within and between transcripts were constantly

---

Table 1  Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>No. of children</th>
<th>Age of child(ren)</th>
<th>Age of GP, years</th>
<th>Area of residence</th>
<th>Partner’s clinician status</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP01</td>
<td>1</td>
<td>11 months</td>
<td>30</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP02</td>
<td>1</td>
<td>14 months</td>
<td>31</td>
<td>West Midlands</td>
<td>Non-clinician</td>
</tr>
<tr>
<td>GP03</td>
<td>2</td>
<td>8 years, 2 years</td>
<td>34</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP04</td>
<td>1</td>
<td>11 months</td>
<td>31</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP05</td>
<td>2</td>
<td>4 years, 2 years</td>
<td>35</td>
<td>West Midlands</td>
<td>Non-clinician</td>
</tr>
<tr>
<td>GP06</td>
<td>2</td>
<td>5 years, 4 years</td>
<td>41</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP07</td>
<td>2</td>
<td>8 years, 4 years</td>
<td>38</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP08</td>
<td>2</td>
<td>4 years, 16 months</td>
<td>33</td>
<td>West Midlands</td>
<td>Non-clinician</td>
</tr>
<tr>
<td>GP09</td>
<td>1</td>
<td>8 months</td>
<td>31</td>
<td>Cumbria</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP10</td>
<td>3</td>
<td>11 years, 8 years, 3 years</td>
<td>40</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP11</td>
<td>1</td>
<td>2 years</td>
<td>38</td>
<td>Cumbria</td>
<td>Non-clinician</td>
</tr>
<tr>
<td>GP12</td>
<td>1</td>
<td>4 years</td>
<td>37</td>
<td>Cumbria</td>
<td>Non-clinician</td>
</tr>
<tr>
<td>GP13</td>
<td>1</td>
<td>1 year</td>
<td>34</td>
<td>Cumbria</td>
<td>Clinician</td>
</tr>
<tr>
<td>GP14</td>
<td>2</td>
<td>4 years, 2 years</td>
<td>39</td>
<td>West Midlands</td>
<td>Clinician</td>
</tr>
</tbody>
</table>
made. Memos minimized definitional drift in coding. Primary analysis and interpretations were carried out independently by one researcher (AM) and regularly discussed between researchers to achieve maximum rigor. Differences in interpretation were resolved and if necessary redefined. No new themes or categories emerged from interview 11 onwards; data saturation was considered to have been reached and interviews were terminated after 14 had been conducted.

Results

Data was conceptualized into four main themes that influenced GP–patients’ perceptions of maternity care:

1. Medical knowledge and skill
2. Interactions with Health care professionals
3. Expectations
4. Difficulties adopting a patient role

Within each theme, subthemes describe both the positive and negative aspects of how occupation affected experiences. The overlap and interaction between themes is significant, reflecting the close interplay these factors have in the GPs’ experience of maternity care.

Medical knowledge and skill

Data demonstrated different ways the GP–patients’ knowledge and skills both assisted with care as well as having a negative impact. Participants felt able to access information from medical journals, websites, guidelines and personal contact with consultants. However, of the 14 GPs in this study, 4 reported that they did not use these sources:

I must admit, not medical books, I suppose I used just what any other mum would like prepare for the baby, and feeding, and the little books they give you, I didn’t want to medicalise it. (GP06)

Knowledge about different hospitals in the area and of HCPs’ competence affected care choices the GPs made and empowered them to choose their preferred practitioners and labour units:

It is in some way to do with the competence of people on the labour ward, and I think that is what is frightening ... so I wanted to be under a certain consultant’s care. (GP07)

In some cases, this choice was made deliberately to increase likelihood of ‘non-standard’ care.

The reason I didn’t want to deliver at the [Name of hospital] Hospital is because they actually treat you like a patient ... because they have so many doctors and nurses delivering there you get no special treatment. (GP10)

Participants also used their status and medical knowledge to influence treatment decisions, thus receiving the care they really wanted. GPs felt empowered to question or challenge routine tests:

But I suppose if I wasn’t a doctor, I wouldn’t have known and I would have just gone and had the GTT, but because I was a doctor I didn’t want to have a test if I didn’t need to have it. (GP02)

Many participants identified other aspects of their care where they used their knowledge to interfere or circumnavigate care. Participants felt able to get more appropriate care and also intervene if they felt care was substandard or not timely:

Working out for yourself that I think I’m anaemic. You know to be told, ‘we haven’t heard anything, it must be ok’ and to have to frog march them to the desk to make the phone call and then they make the phone call you’re actually 6.3 and you need an urgent transfusion. (GP06)

In spite of this, intervening was also seen as a disadvantage by removing HCPs’ responsibility for decisions, resulting in mistakes or delayed treatment:

I felt that I probably led that ODP [Operating Department Practitioner] astray because I interfered by saying I may have a cold and I shouldn’t have said anything, and I think if I had let him do his job he may well have got to the bottom of it a bit sooner and not 3 or 4 days later so that’s where I think it was detrimental. (GP06)

Some GPs perceived that HCPs did not want to take responsibility for care decisions when treating them. HCPs might assume that GPs had a level of knowledge and therefore took a step back in determining management plans or information delivery. Participants expressed concerns about this and wanted to be ‘treated like anyone else’ (GP04):

Because I was a GP they assumed that you would say something or they assumed that you would know what to do so I think they were probably less proactive, less helpful than they might have been otherwise. (GP05)

Medical training and GPs’ experience of practicing maternity care provides some knowledge but GPs acknowledged this alone did not prepare them for being a patient during their own pregnancy:

However many children you have delivered it’s still not the same as you doing it. (GP05)
Some participants acknowledged that they did not know everything necessary for their pregnancy but ‘you learn an awful lot from your first experience’ (GP06) and their experience demonstrated ‘being a doctor didn’t make things any easier’ (GP03):

As a doctor you get told about disease but you don’t always know what’s normal. (GP07)

Furthermore, some GPs found it difficult to ask questions without feeling humiliated or embarrassed:

I think sometimes when you might want to know things but you might be too embarrassed to ask, because there is that assumption that you are medically trained: “I am sure you know what this means” and you don’t want to keep asking well can you explain this and can you explain that. (GP07)

**Interactions with HCPs**

GP–patients’ interactions with HCPs were clearly influenced by knowledge issues. Separate to this, the GP–patient status and personal relationships with HCPs influenced their experiences in maternity care. All but one of the participants were satisfied with their care overall; the majority commenting positively about the experience. However, problems were also expressed.

Some participants felt that HCPs could be ‘more open’ (GP01) with GP–patients; however, the same participant acknowledged ‘Some could be more threatened by GPs.’ (GP01). Experience and personality altered the HCP approach. Other participants commented on how the HCP acknowledged their GP status, but also emphasized they were going to ignore this:

My midwife was very good actually, she said I am going to forget you are a doctor and ignore the fact you are a doctor, and I think she did and she just treated me like everyone else. (GP06)

GPs positively reflected on this attitude. Many participants said that they received the same care any other patient would; for example, they still had to ‘queue an awful long time’ (GP04). However, 11 of 14 also recognized care was on a more personal level and felt they received ‘specialised care’ (GP01). Among participants, many had personal friendships with HCPs treating them or knew them from referring their own patients. Colleague consideration was given to participants, including seven GPs receiving consultant care, as opposed to midwifery care and many had a private post-natal ward:

Because I was a doctor and they did actually say we will give you a separate room because you put in a lot so we can give you something back by giving you a private room. (GP08)

Those with previous relationships commented on a positive interaction. When there was no enhanced relationship present, communication problems were much more common. A few GPs found consultations frustrating either because they were aware of treatments that were unknown to the HCPs or ‘it was not how I would have done it’ (GP02). As suggested in previous literature a hierarchical difference between midwives and GPs was evident:

I think midwives would have been maybe more at ease with other patients, as in non-medical patients where as they were like, “do I need to tell her this because she is a GP”. So they were kind of reserved, I thought. (GP03)

As a result of this, some midwives were seen as providing insufficient information leading to a lack of care. GPs expressed the view that this was due to false assumptions made by HCPs about the GPs’ level of knowledge:

One midwife did actually say to me: “You know, I’ll leave you to it [breastfeeding]”, which I just thought it was shocking because I haven’t done this before. (GP01)

Where the doctor–patients’ partner (father of the child in all cases) was non-clinical, this may have acted to improve communication, as there was a need to include him in discussions that led to their demedicalization.

**Expectations**

GP–patients’ expectations of their care formed a discrete theme in itself, although again related to knowledge, which formed the basis of subsequent expectations. One participant mentioned how their high expectations reflected positively on their care; as the HCP felt under pressure to meet these:

I do think that if you do say you are a doctor you do get treated differently and generally I would say probably for the better actually because other people know that you’ve got your certain expectations and you know what should be expected of treatment and care. (GP01)

Many participants reported that they were better off compared to other patients because they knew what to expect and or when they needed to seek medical advice:

In one sense I wasn’t frightened of the delivery because I had seen so many deliveries. I wasn’t frightened of the pain because I knew what could be done to help with the pain. So it probably helped prepare, in fact I had so much experience from that point of view that I probably felt quite confident. (GP02)
GPs’ experience of caring for others and facilitating deliveries helped them some of the time. However on balance, the majority (12/14) identified knowledge of possible complications made them more rather than less anxious, anticipating complications for their pregnancy:

I think as a doctor you focus on the negative things, so I think you just, being a doctor doesn’t prepare you for having a baby at all actually, I think it just makes you aware of what can go wrong. (GP06)

One GP reflected that her expectations of her midwife were probably too high and this had a negative influence on the rapport between them:

So really specific questions and all she could tell me was... what I already knew myself but my expectations were probably a bit high. (GP02)

Overall, the majority of participants felt their expectations resulted in the experience of the pregnancy being less relaxed than they expected it would have been.

**Difficulties adopting a patient role**

Previous literature suggests that there are difficulties for doctor–patients, notably accepting a patient role and this was evident as the final theme in this study. The impact was described as ‘finding it very difficult to be a patient’ (GP02). Many GPs expressed difficulties in giving up their role as a doctor:

My husband said to me afterwards, you know whenever he was just in the room with me I wasn’t with it like I couldn’t have a conversation, but whenever like a midwife or doctor came in he said “suddenly I just got with it and was asking, like trying to have a conversation with them”. I wanted to continue to have like you know almost like a professional relationship with these people and I almost didn’t want to give over to being a patient. (GP02)

The GPs articulated the dilemma between being treated as any other patient; wanting special care, still wanting to be consulted as a fellow professional and the difficulty this presents for the caring HCP.

Even when GPs do try and accept the patient role, complaining about care was particularly difficult. Four of the 14 participants considered putting in complaints but did not feel doing so would help them move on or accept the errors more easily. Two of these felt unable to complain because of being a doctor:

Reluctant to take it up as a complaint because I felt part of the fraternity. (GP07)

Thus, it is clear that there are both barriers and advantages that a GPs’ occupation has on the experience of being a patient in a maternal setting.

**Discussion**

Overall, GP–patients felt that they received better maternity care as a result of their occupation; many receiving colleague consideration, consultant based care and a private post-natal ward. GP–patients benefited from using their own medical skills and knowledge to aid their care. However, this knowledge did not sufficiently prepare them for their experience and was sometimes detrimental. GPs perceived that HCPs assumed that they had more knowledge than they actually did have, resulting in a lack of care and information in some cases. At times, GPs, disappointingly, felt they were supervised less than other patients, resulting in clinical problems. However, where GPs already had prior relationships with HCPs, communication and satisfaction were better. Although participants wanted to be treated as patients, many had difficulties accepting the patient role, wanting to be treated as both knowledgeable professionals and a standard patient concurrently. This ambiguity in expectations may complicate care and open discussion between pregnant doctors and treating HCPs to address this may improve the experience for both parties.

This study consisted of interviews only. While focus groups may have generated discussion, given the sensitive nature of the topic, this would have been inappropriate. Despite the small sample, data saturation was reached in interview 10. With no new themes emerging subsequently, this suggested that key themes had all been identified. Participants were trained and received care in different locations increasing geographical representation.

Reflexivity was engaged by the lead researcher (AM) through note making during and after the interviews to identify and reduce personal influences and themes were discussed repeatedly by the researchers, enhancing utility of findings. However, it should be noted that available timescales prohibited participant verification which may impact on data validity and should be included in future work.

The interviewer (AM) was an intercalating medical student. Teaching responsibilities of GPs in this study were unknown but it is possible that some GPs restricted information in recognition that they may encounter the researcher in a teaching capacity. However, the researcher knew no participant and the researcher’s perception was of frank and open sharing of information in interviews.

Previous literature only shows barriers doctor–patients face accessing health care, including difficulties accepting a patient role, communication problems due to knowledge assumptions and embarrassment when the doctor–patient asked questions. Recently, the British Medical Association identified these barriers, giving advice stating doctor–patients need to be treated like other patients.
Although this recommendation was not available at the time participants in this study were receiving maternity care, the study results are consistent with their findings, although in light of the ambiguity highlighted in this study putting this recommendation into practice may introduce dissatisfaction with care.

This study highlights a previously unexplored experience of doctor–patients and shows previously undemonstrated positive effects for GPs accessing care. GPs felt that they were advantaged because they were medically trained.

Additionally, they reported undocumented barriers to care. Becoming clinically involved in their own care, possibly disempowering other HCPs meant GP–patients were left without the support offered to other patients. Some GP–patients were more anxious than they expected because of their knowledge of complications that may arise.

Although not a barrier, there was universal comment on the poor quality of breastfeeding advice. Literature suggests that other patients report dissatisfaction with breastfeeding support, so this may not be related to the barriers GPs identified.

This study reports for the first time on the range of experiences and perceptions of GPs during their maternal health care but cannot quantify these. Further research to quantify experiences may enhance understanding of issues that emerged. GPs with serious adverse pregnancy outcomes were excluded and they may have different perspectives on the themes. Evidently, from this study, there are communication problems between doctor–patients and HCPs. Further research should therefore explore the perspectives of HCPs providing maternity care to clinicians. Female GPs approaching pregnancy may find the experiences of other GPs who have experienced childbirth helpful in planning their care. It is evident that there are specific problems facing doctor–patients and HCPs treating them. If details of the barriers across different clinical areas could be established, training and educational packages could be developed for both doctor–patients and HCPs.

Acknowledgements

Many thanks to all the GPs who were interviewed in the study and the Practice Managers who helped to recruit the participants. The authors also acknowledge the support of the Midlands Research Consortium (MidReC) in recruitment. Additional thanks to Deborah McCahon who provided ongoing support during the conduction of this study.

Authors’ contributions: LR conceived the study. AM developed the protocol, gathered the data, undertook the analysis and wrote the first draft of the paper with supervision from LR. Both authors undertook revisions of the manuscript.

Declaration

Funding: this work was supported by the College of Medical and Dental Sciences through the intercalated degree fund and a Primary Care Research Trust (PCRT) grant to AM. The author’s work was independent of the funders who had no involvement in the research process.

Ethical approval: South Birmingham NHS Research Ethics Committee granted approval for the study in February 2010 (reference number 10/H1207/2).

Conflict of interest: none.

References