Considering diverse perspectives when evaluating quality in health care

Anne Barlow (PhD, Midwife)

Anne Barlow
k.anne.barlow@xtra.co.nz
Director, Centre for Midwifery and Women's Health Research, Senior Lecturer, School of Midwifery, Auckland University of Technology (On leave 2004)

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Introduction

The aim of the paper is to consider the value of including diverse stakeholder groups in the evaluation of the quality of professional health care (midwifery). In New Zealand over seventy percent of women -approximately 56,500 - who give birth annually have the care of a Lead Maternity Carer (LMC) midwife with responsibility for antenatal, intra-partum and postnatal care (MOH, 2003). The costs of childbirth interventions are high, for families and health care providers, and therefore excellent midwifery care that supports 'normal' and safe birth outcomes is a key concern for a range of stakeholders. Evaluation methods may contribute to quality improvement in health care and health outcomes, especially in maternity services (Barlow, 2004; Donabedian, 1988, 1990; Kwast, 1998). A series of evaluation projects that have valued the roles, responsibilities and 'voices' of diverse key stakeholders, including consumers of maternity care, have proved useful for identifying and supporting aspects of good practice.

This paper will focus on consumers, midwives, health service providers and policy makers, and discuss the need to represent their diversity in the evaluation of midwifery care. The influence of evaluators' philosophical perspectives will also be considered.

Quality in health care

Defining 'quality' in health care can depend on perspective and context. According to (Ovretveit, 1992) quality in health care means a service "which gives people what they need, as well as what they want at the lowest possible cost." Within health structures generally, poor quality reduces the cost effectiveness of services, increases societal costs, restrains options for providers and frustrates languishing waiting list communities. Evaluation methods may assist in examining and supporting good practice and numerous stakeholders represent diverse values and goals in the achievement and maintenance of health care quality.

Donabedian wrote seminally about the nature of health quality assessment stating, "it is necessary to come to some agreement on what the elements that constitute it are" before quality can be assessed (Donabedian, 1988). Drawing, it seems, on systems analysis, he proposed that there were *structure*, *process*, and *outcomes* aspects of health care delivery. Structure related to the attributes of the setting, the context and resources such as money, time, and people available. Process related to the day-to-day events and care provision.

Short or long-term outcomes related to the effects of health care on the individual and on the population. Donabedian's model has been debated as it assumes causality, although the World Health Organisation has considered indicators of good obstetric and midwifery care and suggested that 'good' quality health process is a function of 'good' organisational structure and 'good' health processes determine 'good' outcomes (Department of Reproductive Health and Research (RHR), retrieved 2003). Donabedian also believed that between all of these aspects were important relationships, not least interpersonal and social.

Stakeholder groups

Any evaluation of a service or organisation providing health care has a number of key individuals and groups with an interest in the care provided and the quality of that care. The term 'stakeholder' derives from organisational theory and refers to any "interest groups, parties, actors, claimants and institutions, internal and external to the organisation that exerts a hold on it," (Bronn & Bronn, 2003). Bronn and Bronn suggest that any stakeholder –not just customers - can have an impact on an organisation and its performance.

Stakeholder groups distinguish themselves by having a different set of assumptions regarding a particular situation. According to stakeholder theory there is a 'ladder of inference' within a cycle of reflection that links one's beliefs of reality and assumptions about the world, to the cultural meanings that are attributed to information and observations, and to subsequent actions. That is, where stakeholders have different world views, values and expectations, perceptions can result in different interpretations of events and outcomes of actions. Although stakeholders may subscribe to an espoused theory of practice, Bronn and Bronn (2003) claim models-in-use may more accurately depict what is actually happening. One of the evaluator's roles or skills therefore, is to identify the important issues behind various stakeholder statements and seek to explore difference and congruence amongst various interpretations of events. By understanding the diversity amongst stakeholders, key issues are more readily identified and relevant means for evaluation dissemination and use are more likely.

Stakeholders in the evaluation of maternity care

Key stakeholders in the provision and evaluation of health care can be listed as those providing care, those funding, and those receiving care, including their families and communities. In New Zealand maternity services for example, stakeholders include consumers, consumer organisations, families and communities receiving care, regional district health boards (DHBs), maternity service provider organisations (MPOs), public and private hospitals, practising DHB-and self-employed midwifery and medical professionals, other health and allied professionals, legal and professional organisations, such as the New Zealand College of Midwives, educational institutions, midwifery and medical teachers and students, and Ministry of Health and government social policy and decision-makers. The views of members of New Zealand consumer groups are warranted in maternity health forums, for example, Home Birth Association, Parents Centre, La Leche League, Women's Health Action and Maternity Services Consumer Councils play an active role in provision of maternity care. Various individuals and representatives for

cultural groups within hospital and community organisations may also have a voice in health evaluation and decision making, and New Zealand health ethics committees provide guidelines for research and evaluation with Maori to ensure appropriate consultation and involvement (Health Research Council of New Zealand, 2003).

It is generally understood that not all stakeholders will be included or have their needs met by an evaluation, although a successful implementation and evaluation utility are often determined by the level of involvement of the evaluators with evaluation programme participants and key stakeholders (Neale, 2003; Owen, 1996; Patton, 2004).

As stakeholders have an interest in the provision, quality improvement and evaluation of health care, it is important that there is appropriate consideration of various positions when making judgments about the quality of maternity services and midwifery care. Their opinions, values and philosophies can be represented or marginalised by the scope of an evaluation and methods that impact on what counts as knowledge (Greene, 1997, 2002).

Representing diverse philosophical goals and values in the evaluation of midwifery care

Midwives

The nature of the social, cultural, political and historical context that influences the philosophies and perspectives of health professionals needs to be reflected on or contemplated when considering professional practice activities.

Maternity services in New Zealand for example have been shaped by rapid and radical health services restructuring and changes in the last two decades. The Nurses Amendment Act 1990 secured midwifery autonomy which meant that midwives could conduct ‘normal’ childbirth in hospitals and homes without a doctor needing to be present (New Zealand Government, 1990). It resulted in an increasing number of midwives establishing practices independently from large hospital clinics. In small community units clinical management was led by midwives, with access to consultation and referral to base hospitals. A midwifery philosophy was articulated by the profession following the Act amendment. This midwifery philosophy supported partnership with women and continuity of care during antenatal, labour and postnatal periods (Guilliland & Pairman, 1995). It is holistic, woman and family centered and values the relationships between midwives and clients. National Standards for Practice and ethical guidelines were also developed with consumers (NZCOM, 1993, 2002). Today these standards are credited with informing ‘best practice’ decision making and used when making evaluations of practice by NZCOM professional practice review committees, and by other monitoring organisations such as Accident Compensation Corporation (ACC) and the government Health and Disability Commission.

Not all practitioners however, subscribe to the same values or philosophy and this can be a source of difference amongst midwives and within midwifery groups or maternity organisations that may affect evaluations of care. In a study of a small community midwifery-led maternity unit, for example, midwives held distinct views relating to

midwifery and medical models of practice that affected how they practised and the relationships that they held with women and with each other. In this evaluation the information about midwifery philosophy helped to understand clinical practice, and data such as the maternal and infant birth outcomes statistics that were collected as part of the study. Here are some examples from this study that illustrate philosophical differences amongst midwives:

> *In one camp there is the nurse-trained midwife who looks to (the large base hospital) as if it is the guiding light. The other group like the distance from (the base hospital) and have a view of birth as bringing control back to women. The struggle is a good one and eventually we will find middle ground (Midwife E).*
>
> *Within the Unit the midwives tend to get little groups and this can reduce the unity amongst the staff –because there are diverse areas of practice. People's beliefs are different, people's training backgrounds are different, and people's cultures are different. So you're going to have diversity, because you have these differences (Focus group midwives 4).*
>
> *We are still in an era of change and some of the philosophies are poles apart. We need an in-house study day re attitudes. Unless you are in the other person's shoes, you don't really know what it feels like for that person (Midwife I)*
> *(Barlow, Hunter, Conroy, & Lennan, 2003).*

The relationship of midwifery philosophy and best practice was more clearly outlined in another study, where having a similar philosophy was the key factor perceived to contribute to a successfully functioning midwifery group and good birth outcomes for women:

> *What supports 'best practice' is people of like-minded beliefs and philosophies and practice (Midwife E)*
> *(Barlow, Berman, & Lennan, 2004).*

Women/consumers

Since the 1980s, feminist issues and human rights concerns have coincided with numbers of women demanding control over their bodies, their reproductive processes and their birth events. A significant influence on New Zealand maternity services has been the *'Cartwright Report' (Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into other Related Matters, 1988).* The Report on cancer research undertaken without stakeholder information or consent has increased public sensitivities to women's health services, health research and professional accountability. The Report documented a need for:

- informed consent, rather than clinical freedom,
- support for peer review of health professionals practice and,
- support for improved relationships between health practitioners and clients.

The need for consumers of health care to have a voice in the ethical management of social research has resulted in women and their families increasingly being included in evaluations and assessments of maternity services. In the midwifery research centre where I work for example, a range of stakeholders including consumer representatives have formed an 'advisory group' that meets regularly and provides evaluation and research advice and critique. A Kawa Whakaruruhau Committee within the Health Faculty at the University also advises on Maori research methods and issues.

Women's perspectives about birth and a range of life experiences shape their assumptions and expectations about midwifery care. Birth outcomes can influence a woman's decision making and how she determines the constituents of good quality care (Lennan, 1997; Page, 2000). Lennan, for example, suggests that women's voices in maternity services have traditionally been ignored or unacknowledged, particularly with the use of client satisfaction surveys for monitoring women's views on quality of care. These approaches alone can have limitations for a wide range of consumers, especially Maori and Pacific Island groups, or where English is a second language, and particularly for postnatal mothers who just want to cope with the difficulties of managing lifestyle, mental, emotional and physical changes, and a new baby. A greater interpretation of women's stories about their birth experience and qualitative interview or narratives methods may capture insights about quality more rigorously (Kirkham, 1997).

In one study the General Manager of the women's health service requested an understanding about women's perspectives, as she felt it could contribute to making economic decisions about the use and sustainability of a community midwifery-led maternity unit. It has been useful to have a group of midwife and non-midwife researchers, including an anthropologist, to gather evaluation information from women. Attention to beliefs about birth and the 'normality' of giving birth in a low technology birthing unit, as opposed to a high technology obstetric hospital, for example, elicited the following different responses from women:

> *I went to (the large hospital) because I didn't want to transfer (from the community unit) if anything went wrong, a kind of risk aversion. I was reluctant to take the risk that something would go wrong.*
>
> *You come here (to the community unit) to have babies, you don't come here because you're sick, and that's the difference. (The large hospital), you go there when you're sick and not for things like having babies (Barlow et al., 2003).*

These statements, not only revealed women's philosophies, but could reflect the types of caregivers that women chose and the preferences and confidence of caregivers (midwives) themselves to practise in either high or low technology environments. Interviews with midwives explored these issues further.

Health service providers

District Health Board, midwives and quality assurance managers all have an interest in the quality and outcomes of their services. (Berwick, 2003) suggests the exchange of narratives and stories within complex health care systems will maximise learning and increase wisdom. Although an organisation may have an 'espoused' stakeholder theory, such as a mission statement or goals for service, in reality health care institutions, and even small midwifery group practices, are constrained by organisational culture, the physical and management structures, human resources available and the level of politics operating within the organisation and context (Bolman & Deal, 1997). Despite a strong practice philosophy and excellent care provision, for example, one group midwifery practice situated within a University relocated to an external community base, because the financial structures did not support a viable service (Barlow et al., 2004). Sometimes similarities and differences between practice philosophies held by managers and midwives are evidenced in site visits that, according to (Straton, 2001) , give opportunities for the evaluator to place herself in the shoes of participants, thus lending credibility and a better understanding of the data. Managers and participants may gain insights by reading evaluation material, understanding via a different conceptual framework, and acknowledging different viewpoints and this can lead to action and change. One midwifery manager, for example, requested a management plan, or a list of possible activities that would support staff change, following her review of an evaluation draft report where different philosophical approaches to midwifery quality assurance were evident (Barlow & Lennan, 2004).

Health funders and policy makers

Government social and political values are reflected in health policies and decision making. Maternity services in New Zealand are provided free for citizens and residents and the lack of a tort system of liability in New Zealand may result in a better quality of care, although Davis, Lay-Yee et al. demonstrated that the risk of serious preventable in-hospital medical injury for patients in New Zealand (approximately 5%) was within the range of comparable investigations in the US, UK and Australia where a fault system exists (Davis, Lay-Yee, Briant, & Scott, 2003; Vincent, 2003). Davis, Lay-Yee et al suggest that the potential impact of the context on the organisation and safety of care is important. Recent government policies have been designed to influence quality improvement and quality assurance in order to reduce the excessive costs of medical error, mishap and *near misses* by health professionals, and international governments promote a systems approach to improving quality (Berwick, 2003; MOH, 2002). The recently legislated Health Professionals Competency Assurance Act 2003 aims to ensure that all registered health practitioners provide evidence of competency regularly, including the evaluation and assessment of clinical practice (New Zealand Government, 2003) . Knowledge of government health philosophy has proved important, therefore, when assessing health needs and maternity services quality, and in examining and understanding the implications for other stakeholders.

Evaluators' philosophy and roles in health care evaluations

The stakeholders' investment in health care and need for quality must be matched in the evaluation by the evaluators understanding of self, a reasonably informed knowledge of the context, and a concern with evaluation ethics. The authors in the midwifery

evaluations noted above made declarations of their philosophies and assumptions about childbirth in the various evaluation reports. For example, one preface states:

> *Each researcher has taken responsibility for an aspect of the study and has brought their life experience and knowledge to the project. They have all been consumers of the New Zealand midwifery and maternity services. A midwifery philosophy and a focus on "keeping birth normal" (Hunter, 2000; Page, 2000, 2001) underpin the assumptions brought to the interpretation of the findings.*
> *(Barlow et al., 2004)*

It has been suggested that to meet stakeholder needs effectively and represent their views within a political context, attention to all appropriate stakeholder views, interests and values is required Neale (2003). It is sometimes necessary to use a range of methods in order to provide an authentic voice and use reflection and deliberation to produce balanced findings.

Conclusions

Notwithstanding the pragmatics of evaluation or the requirement to fulfill contract obligations and meet evaluation objectives, the social and political context of evaluation interacts with participants' and stakeholders' personal theories of the world and stakeholders in maternity care have complex needs and expectations for evaluators to consider. Excellent midwifery clinical decision making depends on knowledge, competencies and skills, and relationships with other health professionals. It rests, however, on professional and personal philosophies and models of practice, and on relationships with women and their families. Women perceive their care within different frameworks of understanding and the health care organisation imposes conditions on practice and choices for women. Overall, government legislation and social policy has considerable influence on health care and all these factors need consideration when gathering evidence and making assumptions about the quality of health care in an evaluation.

Midwifery evaluation can shape and target government decision making and there is an obligation for midwives to provide rigorous data (Sinclair, 2004). The examples provided illustrate the diversity of stakeholders' philosophies and these need consideration in evaluation for findings to ultimately benefit women and their families who are recipients of maternity and midwifery care.

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