Patient-Centred Antenatal Care

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Curriculum vitae

Neil David qualified from Wits in 1985. After completing his internship at Coronation Hospital and a number of other jobs, he commenced Vocational Training at Conradie Hospital in Cape Town where he was based from 1988 to 1990. He wrote the MFGP (SA) in 1990 and was awarded the Claude Harris Leon Medal for his performance in this exam. He worked as an SHO in Obstetrics in the latter part of 1990 at the Peninsula Maternity Hospital. He wrote the Dip Obst (SA) in 1991. He is currently in practice with Dr Stanley Levenstein in Brooklyn, Cape Town and is involved in the Western Cape Vocational Training programme as a trainer.

Summary

Routine antenatal care (the type of care taught at our medical schools, and which concentrates on disease and not on the person with the disease) fails to recognise the widely differing needs of the individual woman. With a patient-centred approach, the doctor can create an opportunity (perhaps the only one!) for the pregnant woman to talk about her feelings and fears and help her address them positively. This change of attitude towards pregnancy may have a remarkable influence on the outcome of pregnancy. A patient history is given to illustrate the approach.

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Much has been written in recent years about the concept of patient-centred care.[1] This way of thinking and practicing medicine has not come about spontaneously but has evolved out of the realisation that conventional medical practice often does not address the needs of our patients, particularly in the general practice setting. Conventional medical education concentrates on the study and management of disease. Scant attention is paid to the feelings and needs of the patients suffering from these diseases. Even less attention is paid to the feelings and needs of people who have no disease, except that we should exclude organic pathology before sending them on their way. We thus emerge, fully trained, with a good knowledge of disease and illness but a poor understanding of the people who are our patients. We are, in short, trained as practitioners of illness-centred medical care.

This approach seems particularly inappropriate in the care of the pregnant woman. Pregnancy is an integral part of a woman's life; a state of womanhood. By its very nature, the illness-centred approach fails fully to appreciate this. While the importance of monitoring the progress of pregnancy detecting any abnormalities and ensuring a physically healthy mother and foetus at the end of pregnancy is indisputable, it will be argued that this level of antenatal care alone fails to address the unique experience of pregnancy and the needs of the woman as an individual. To do this we need to employ patient-centred techniques. We need to "depathologise" pregnancy; to treat the whole person and not merely the part of her that is pregnant. Not only will this result in the patient's perception that she has been well-cared for, but may also favourably influence the outcome of the pregnancy.

The traditional system of antenatal care is based on the premise that it is an important service designed to monitor and manage the progress of pregnancy and that all pregnant women will seek it as long as it is available. However, it has been shown that negative attitudes towards pregnancy, health professionals and the importance of ante-natal care are prevalent amongst women who receive little or no antenatal care.[2] Subsequently, the same investigators attempted, with some success, to demonstrate a causal relationship between negative attitudes

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towards antenatal care and low birth weight.[3] The latter point has been further borne out in a recent French study which showed that the risk of premature birth is significantly increased in women with negative attitudes towards pregnancy.[4]

In this study, a questionnaire was used to assess the attitudes towards pregnancy in a large group of women in their second trimester, attending antenatal clinics in Lyon, France, over

Risk of prematurity increased by negativity

a two year period. The questionnaire included questions relating to the woman's perception of the effects of pregnancy on the body, feelings of fulfilment during pregnancy, attitudes towards daily life and behaviour while pregnant, role of the baby's father, family ties, and beliefs and superstitions. The investigators conclude that psychological factors "...may affect pregnant women and be associated with premature birth. This new component must be considered in the development of policies for preventing premature birth."[4]

From the above, it becomes evident that routine antenatal care as it is commonly practiced may fail to recognise the widely differing needs of the individual woman. An example is that of a 21-year old unmarried primigravid woman who I saw for the first time at 30 weeks gestation. She had been diagnosed early and had a confirmatory ultra-sound, the report of which she gave to me, but she had not sought any antenatal care in the interceding months. She was living with the baby's father and they both had clerical jobs with the city council. On her first visit, her only explanation for not seeking antenatal care was that she had felt well and had not had the time. On her second visit we had more time to talk and less routine procedure to get through. It was only when I asked her how she really felt about her pregnancy that she broke down and tearfully admitted that she wanted to put the baby up for adoption. She felt that both she and her boyfriend were too young to take on the responsibility of parents, that they could not afford to provide the baby with a "decent life", and that her pregnancy was not sufficient reason for her to marry the father. Although she was adamant on these points, she told me, to my surprise, that she had not discussed these feelings with her boyfriend and that he was very enthusiastic about becoming a father. It was he, she said, who had made her

Management of disease vs the patients suffering from disease

come to the doctor. She had, in fact, been avoiding antenatal care in order to avoid dealing with her feelings towards the pregnancy.

After much discussion with the patient and her boyfriend, I eventually put them in touch with an adoption agency and the bureaucratic wheels were set in motion. She continued to see me even though she was booked in at a state hospital. As it turned out, she gave birth to a healthy boy in the early hours of Mother's Day and bonded so intensely with the baby that she did not go through with the adoption. She, her boyfriend and the baby are now living together in a small rented house. I have seen the baby a few times since his birthday, and he is clearly happy and much loved by both his parents.

This story may not have had a happy ending. If the patient had not had an opportunity to express her true feelings and attempt to deal with

Trained as doctors of illness-centred medical care

them, she may have been extremely resentful about having this baby. In this case, the patient-centred approach created a forum in which she could come to terms with her confusion and manage it, in what she perceived to be a constructive manner. Without this approach, it is my feeling that doctors may not only have to deal with dissatisfied patients, but may also deprive women of the full enjoyment of pregnancy and at worst cause them to suffer from emotional and physical complications, such as premature birth/low birth-weight.

Interestingly, long-term developmental effects of negative antenatal experiences have also been postulated for the newborn. Experimental animal models have shown that prenatal stress in rodents is associated with a number of long-term behavioural consequences including feminised sexual behaviour in males,[5] altered maternal behaviour in females,[6,7] and various changes in exploratory behaviour, cognitive

performance, and aggression.[8,9] Current research has suggested that these changes may be mediated by stress-induced alterations in foetal brain opiate receptors.[10]

It follows that ideal antenatal care should not only maintain appropriate medical standards during pregnancy, but also address the stresses and psychological needs of the pregnant patient. To do this requires some

Pregnancy and childbirth is a momentous life-change

insight into the possible meaning of pregnancy for the patient. Margaret Oates writes that pregnancy and childbirth, especially if it is for the first time, is the most momentous change of a life-time for women and probably for men as well.[11] Most societies, she says, apart from Western urbanised societies, have well prescribed and documented rituals surrounding childbirth. These serve the function of protecting the mother/infant pair from hazard and provide a support base allowing her to develop the self-confidence and skills of parenthood. Importantly, they also acknowledge her valid dependency needs and give her status in her new role. While there are vestiges of these rituals in our society, such as antenatal clinic attendance, "confinement" procedures, and the six-week postnatal check, many essential elements of the childbirth rite of passage have been lost. Of these, the most important are the acknowledgement of emotional and dependency needs, continuous social support, and acknowledgement of the changed role within marriage, family and society. Also absent is the increased status of motherhood. For many women, the reality may seem as if motherhood detracts from their value as individuals. They may be seen as less reliable employees; motherhood is often used as an argument for non-progression in the professions; babies are unwelcome in the workplace, restaurants, theatres and shops, and sometimes even at family gatherings. In urban South Africa, this scenario assumes tragic proportions as many women find themselves not only without their traditional support bases, but also having to cope with the brutality of poverty and the indignity of political powerlessness.

Thus for many women pregnancy is a fearful path which they are expected to tread largely unsupported by society. It is against this background that the doctor or midwife delivering antenatal care is faced with the task of interpreting common symptoms. It has been my experience, for example

For many urban women, pregnancy is a lonely, fearful path

that with women frequently reporting troublesome vaginal discharges, there is usually nothing more to find than the physiological leucorrhoea of pregnancy. Underlying this, however, there are almost always issues relating to body image and sexual desirability. The commonly reported backache and urinary frequency often relate to inconveniences experienced in the workplace. The symptom of chronic fatigue usually leads to discussion about the lack of support from friends, family and the workplace. These are but a few of the long list of common pregnancy-related symptoms which can be interpreted using the patient-centred approach.

The point is not that we are in a position to address these problems by making drastic changes in people's lives, but that we have given the

An opportunity for pregnant women to talk about their feelings

pregnant woman an opportunity to complain, and thus address her problems herself. Our society is not generally sympathetic towards complaints in pregnancy. Society's attitude is: "If you don't like being pregnant, why did you get pregnant?" The usual response from providers of antenatal care (whether they be doctors or midwives), however caring, is: "It's perfectly natural to feel this way when you're pregnant", implying that the complaints are really unwarranted. On the other hand we may resort to over-investigating or over-treating the patient instead of listening to her complaints. The complaints, however, are there and the patient should be helped to make sense of them. If not, she is likely to carry them with her, resentfully, to term and probably postnatally. It may not always be easy for us to listen to the pregnant woman's problems, as pregnancy is an emotionally-charged situation which induces powerful feelings in doctors and midwives which we may be unaware of. The retreat into the doctor-centred and illness-centred approach is often a defence against

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these feelings. Health workers could consider suitable training, such as participation in Balint Groups, to help them overcome this discomforture.

It is often argued that the patient-centred approach is a luxury which developing countries such as ours can ill-afford. It is my feeling, on the contrary, that patient-centredness is a cost-effective solution to many of our complex health problems, including the delivery of antenatal care. Women with perfectly normal pregnancies frequently have unnecessary laboratory and sonargraphic investigations performed, an excessive number of antenatal visits, unwarranted medication prescribed, and most expensive of all, unnecessary hospital admissions. Much of this expense could be contained by the patient-centred approach.

Patient-centredness is cost effective for complex health problems

The GP is well-placed to apply the concept of patient-centred antenatal care in practice. In Britain, there has been wide acceptance of the view that antenatal care should largely be the responsibility of the GP together with other members of the primary health care team.[12] McWhinney stated the first principle of family medicine as being "The Person, not the Problem: The family physician is committed to the person rather than to a particular body of knowledge, group of diseases or special technique".[13] The GP has the proximity to his or her pregnant patient to recognise and understand the whole person, and to work with the "overall diagnosis" of pregnancy. This argument should also be extended to community midwives, as the bulk of ante-natal care delivered to women in lower socio-economic groups will be through existing community midwifery clinics such as Midwife Obstetric Units (MOU's). In this setting the patient-centred approach is even more crucial as these services will not enjoy the pre-conception and post-peurperium continuity of the general practice setting.

McWhinney writes that "in practising the patient-centred clinical method, the physician attaches equal importance to following the traditional medical agenda and to understanding the meaning the illness (condition) has for the patient. This involves understanding the patient's expectations, feelings and fears. Reaching this understanding should be an objective in every clinical encounter".[14] For the pregnant woman on her antenatal visit, this approach is not only desirable, but likely to be of significant benefit to both mother and unborn child.

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