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# PATIENTS' ATTITUDES TOWARDS THE QUALITY OF OBSTETRIC SERVICES IN A TERTIARY LEVEL OBSTETRIC FACILITY UNIT

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***Abstract.*** *The growing recognition of patients' roles as key evaluators of service quality in the healthcare quality improvement process – as well as periodic media coverage of adverse birth experiences, such as postpartum depression, that place burdens on mothers and society in general – encourages a broader examination of the aspects that form the quality of midwifery services. The relevance of this topic is also determined by the emphasis on the role of the obstetric service sector in the Lithuanian Health Programme, which provides long-term directions for improving the quality of services provided to mothers. Quality assurance of maternity services is also one of the main scopes of the World Health Organization's activity. The aim of this study is to evaluate the attitudes of patients towards the quality of obstetric services provided. A quantitative survey was conducted at a tertiary level obstetric facility unit involving 309 women who had given birth. Respondents participated in the study by submitting a service quality evaluation questionnaire, and the total internal reliability of the questionnaire was 0.966. The research revealed that, although the quality of maternity services in the institution where the research was conducted was assessed as high, the need for women to actively participate in their health care process is not ensured sufficiently and communicative aspects of the provision of services can be improved. Women who undergo vaginal delivery and have episiotomies, as well as women who are not guaranteed early contact with the newborn immediately after giving birth, require special attention on behalf of the medical staff. This is first ensured by realizing the need for effective communication between the patient and healthcare specialists in order to improve the quality of the services provided. Assessing rapid changes in the healthcare service quality field and the constant emergence of new factors defining quality of services, it becomes obvious that standard quality assessment questionnaires for obstetric situations must be constantly reviewed, and quality assessment must be carried out periodically using questionnaires focused specifically on obstetrical practice.*

***Keywords:*** *quality of services, patient, maternity care, quality assessment.*

***Reikšminiai žodžiai:*** *paslaugų kokybė, pacientas, akušerija, kokybės vertinimas.*

## 1. Introduction

One of the criteria defining the quality of services as formulated by the World Health Organization (WHO) is a patient-oriented approach in accordance with the individual preferences, needs, and values of the patient (World Health Organization 2018a). In fact, the personal experience of patients receiving healthcare services is one of the three main components that define the quality of healthcare, along with the assessment of patient safety and clinical effectiveness. Moreover, the inclusion of patients and the public in the healthcare quality research process is essential for quality improvement and is a well-established principle (Locock et al. 2019). The role of the patient as the main evaluator of the quality of services, as well as the importance of a patient-orientated approach when providing them, is established in a number of legal acts of the Republic of Lithuania as one of the objectives for improving the quality of healthcare services in our country (LR SAM įsakymas, 2017).

Recently, it has become extremely important to examine the attitudes of pregnant women and mothers – as they are the main quality evaluators of obstetric services – after observing extremely high rates of postpartum depression and dissatisfaction with the quality of maternity services provided all over the country. Globally, the incidence of postpartum depression is 17.22%; however, significant cross-border and cross-cultural variations are recorded (Wang et al. 2021). There are no reliable statistics of postpartum depression cases in Lithuania. In response to this and other problems associated with the quality of obstetric services (a high incidence of obstetric violence, which is a fairly new concept in obstetrics and was first mentioned in the year 2010; an increase in home births, etc.), in 2018 the WHO published 12 principles of respectful maternity care (Table 1) aimed at improving both the technical and functional quality of the service, prioritizing a holistic, human rights-based approach. The WHO also provided recommendations necessary to ensure a positive birth experience (Table 1) (World Health Organization 2018b).

**Table 1.** The 12 WHO principles of respectful maternity care and recommendations for ensuring a positive birth experience

| ***Principles of respectful maternity care*** |
|---|
| 1. Being free from harm and mistreatment<br>2. Maintaining privacy and confidentiality<br>3. Preserving women's dignity<br>4. Prospective provision of information and seeking informed consent<br>5. Ensuring continuous access to family and community support<br>6. Enhancing quality of physical environment and resources<br>7. Providing equitable maternity care<br>8. Engaging with effective communication<br>9. Respecting women's choices that strengthen their capabilities to give birth<br>10. Availability of competent and motivated human resources<br>11. Provision of efficient and effective care<br>12. Continuity of care |
| ***Recommendations for ensuring a positive birth experience*** |
| 1. Respect-based maternity care<br>2. Effective communication<br>3. The possibility of having an attendant/attendants during the birth<br>4. Continuity of care including antenatal, intranatal, postnatal care (provided by obstetricians) |

However, despite the fact that the recommendations provided by the WHO are widely available and should be applied in all health care systems and institutions (taking into account the obstetrical facilities of each country), the majority of obstetricians and obstetrician-gynecologists in Lithuania are not familiar with these provisions. Although compliance with many of these provisions can sometimes be taken for granted in obstetrical practice, some aspects, from the perspective of patients, require special attention in order to comprehensively improve the quality of services.

The main factor complicating the provision of healthcare services and causing dissatisfaction with the quality of services among patients in general is the lack of effective communication between patients and medical staff (Hudson Smith and Smith 2018; Chmiel 2019; Lilleheie et al. 2020; Odai-Afotey et al. 2020). Although there are some studies on the evaluation of the quality of services from the patient's perspective in obstetrics, aspects of communication between staff and pregnant women are also emphasized as causing the most problems (Lippke et al. 2019; Rowe et al. 2002). Considering the influence of negative childbirth experiences on the quality of life of mothers and the impact on the newborn – especially if the mother suffers from postpartum depression, which is often aggravated by factors related to childbirth care – research on this topic is certainly not sufficient. There is a lack of a complex assessment of the technical and functional quality-defining factors observed. It should also be mentioned that there is an increasing amount of evidence confirming the correlation between patients' experiences when receiving healthcare services and health outcomes (Hudson Smith and Smith 2018). Therefore, research on patient satisfaction with the quality of services directed towards a specific health care field must be conducted more often.

**Research aim:** to assess patients' (pregnant women) attitudes towards the quality of obstetric services provided.

## 2. Methodology

### 2.1. Research organization

Quantitative research using the questionnaire survey method was conducted in a health care facility unit providing tertiary obstetric services. In total, 364 completed questionnaires were received – a return rate of 91% – from which 309 questionnaires were used (55 questionnaires, or 15%, were not suitable due to the exclusion criteria).

### 2.2. Inclusion/exclusion criteria

The study included women who gave birth vaginally and by caesarean section (C-section). All respondents expressed their consent to participate in the study. Due to the circumstances complicating the assessment and determining a higher level of subjectivity, this study did not include patients who were diagnosed with coronavirus infection on admission or during hospitalization, did not speak/understand the Lithuanian language, or delivered a non-viable fetus (death of the fetus in the womb or during childbirth).

### 2.3. Research instrument

The questionnaire for the quality assessment of obstetric services was compiled by the authors of this research based on one of the most widely used questionnaires for assessing the quality of services provided by healthcare institutions – Ferguson et al. (1999). This form of questionnaire is used to evaluate technical (an external expression of quality related to available resources and the technological process of service provision) and functional (describing how the service

is provided and the circumstances of its provision) quality aspects as well as external efficiency, and allows researchers to estimate the overall quality of services. According to this questionnaire, four main blocks of questions were formed. However, although the components assessed by the Ferguson questionnaire are versatile and include the main factors of the service provision process, modifications to the study instrument taking into account the specifics of obstetrical practice were necessary. A number of studies investigating the satisfaction of pregnant women with the quality of services in maternity units use Prof. Bodil Wilde-Larsson's structured questionnaire "*An intrapartal-specific QPP-questionnaire (QPP-I).*" This questionnaire is specifically adapted for the evaluation of the quality of care during childbirth (Wilde-Larsson et al. 2010). However, although this questionnaire includes some of the main quality aspects in obstetrical practice (staff competence, physical environment, person-oriented approach, assessment of socio-cultural environment), since 2010, with the rapid development and evolution of patient-oriented, value-based healthcare and the respect-based concepts of maternity care, instruments for assessing satisfaction with the quality of services must also evolve. Moreover, taking into account the differences between various health systems even in the same geographical region and the specific nuances of clinical practice in each country or even in each healthcare unit, each country and healthcare organization should have its own service quality assessment instruments (Endeshaw 2021). Therefore, in this study, maintaining the structure of the questionnaires used in healthcare quality research (based on the Ferguson questionnaire), and taking into account the quality aspects prevailing in the questionnaires focused specifically on maternity care (based on the QPP-1 questionnaire), a 50-question survey was compiled by the authors, with a focus on the latest aspects that determine service quality. The instrument of this study consists of technical quality indicators (10 questions), functional quality indicators (24 questions), indicators allowing the evaluation of external efficiency (6 questions), and analysis of certain specific factors affecting patients' assessments (10 questions).

A five-point Likert scale was used to mark the statements related to aspects of service quality assessment in the questionnaire given to patients, where 0 represented "did not evaluate/did not apply to me"; 1 "completely disagree"; 2 "partially agree"; 3 "agree"; and 4 "completely agree". The internal reliability of the questionnaire scale was assessed by calculating Cronbach's alpha coefficient for each block of questions (Table 2).

**Table 2.** Cronbach's alpha coefficients for each block of questions

| Quantitative Research Questionnaire Scales and Subscales | Cronbach's Alpha |
|---|---|
| TECHNICAL QUALITY | 0.936 |
| Environment of the maternity unit | 0.878 |
| Arrangement of the premises | 0.858 |
| Availability of services | 0.768 |
| Staff qualification/competence | 0.976 |
| FUNCTIONAL QUALITY | 0.950 |
| Communication with medical staff | 0.950 |
| Provision of information | 0.912 |
| Participation in decision-making (patient empowerment) | 0.838 |

| | |
|---|---|
| Staff empathy | 0.885 |
| Communication with other medical staff | 0.759 |
| SPECIFIC FACTORS AFFECTING THE ASSESSMENT | 0.704 |
| EXTERNAL EFFECTIVENESS | 0.953 |

In all cases, Cronbach's alpha was >0.7, indicating the eligible internal compatibility of the questionnaire. The total internal reliability of the questionnaire was 0.966, so the research instrument was valid and suitable for this type or research. In order to check the comprehensibility of the questionnaire for the respondents participating in the study, a pilot study (10 forms) was conducted.

### 2.4. Research ethics

Permission was obtained from the bioethics committee of the healthcare institution to conduct a survey of patients in the maternity department. Respondents were free to decide on their participation in the study. During the research, the anonymity of all respondents was ensured: information identifying the participants was not required, and during data analysis each respondent was given a unique number. The questionnaire was compiled so as not to violate the cultural, moral, or religious values of the participants.

### 2.5. Data analysis methods

All research data was calculated using the SPSS (Statistical Package for Social Sciences) software (version 20) and Microsoft Office Excel. Means and standard deviations (SD) were calculated for data expressed on an interval (Likert) scale, and frequencies in percent (%) were calculated for data expressed on an ordinal scale. In order to compare how the obtained results differed in different groups of respondents, the Mann–Whitney U criteria (when data distribution differed significantly from normal distribution and results were compared between two groups – two independent samples) and the Kruskal–Wallis H criteria (when data distribution from normal distribution differed significantly and results were compared between three or more groups – three or more independent samples) were calculated. In all cases, a difference with a reliability greater than 95% ($p < 0.05$) was considered statistically significant.

## 3. Results and discussion

Socio-demographic characteristics of the participants

The research sample consisted of 309 pregnant women aged 19 to 47 (an average age of 32). Most of the respondents were urban residents (96%), had higher university education (84%), were employed (97%) and were married (73%) (Table 3).

**Table 3.** Socio-demographic characteristics of the respondents

| **Characteristics** | | **Patients ($N$ = 309)** | |
|---|---|---|---|
| **Age** | | 19–47 years old<br>32.0 ± 5.6 years | |
| – | | N, unit. | % |
| **Place of residence** | Countryside | 12 | 3.9% |
| | Urban district | 297 | 96.1% |
| **Education** | Unfinished high school | 0 | 0.0% |
| | High school | 4 | 1.3% |
| | Higher non-university | 44 | 14.2% |
| | University | 261 | 84.5% |
| **Social status** | Student (school or university) | 5 | 1.6% |
| | Employed | 299 | 96.8% |
| | Unemployed | 5 | 1.6% |
| **Marital status** | Single | 1 | 0.3% |
| | Partnership | 81 | 26.2% |
| | Married | 227 | 73.5% |
| | Divorced | 0 | 0.0% |

General evaluation of research scales from patients' perspectives

Of the three main blocks of questions, the respondents rated external efficiency (mean 3.55) and technical quality of services (mean 3.32) highest. Among the subscale of technical quality, staff qualification (mean 3.44) and arrangement of the premises (mean 3.40) were rated best. The lowest-rated subscale was the availability of services (mean 3.11) (Figure 1).

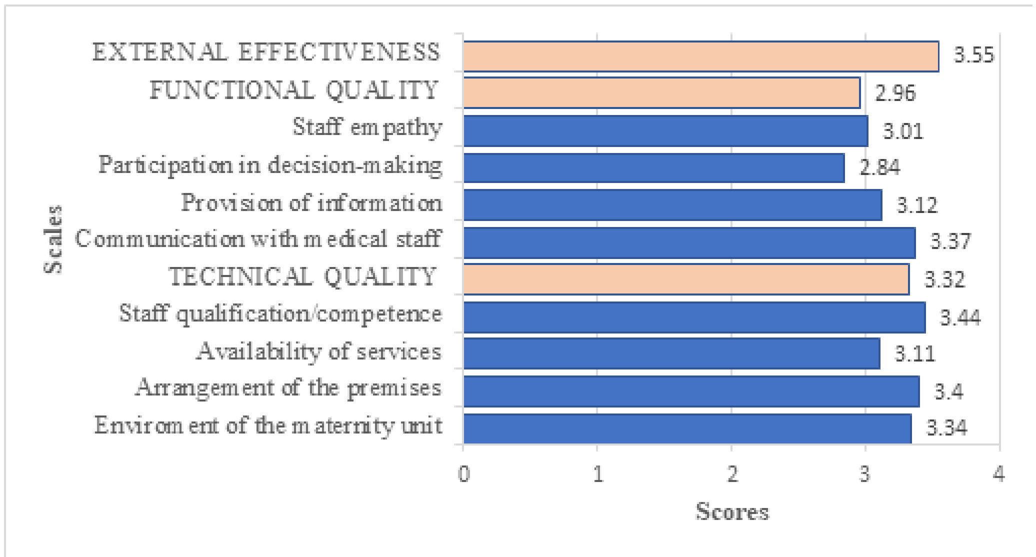



**Figure 1.** Evaluating research scales from the patients' perspective

According to many studies conducted both in Lithuania and worldwide, patients tend to rate aspects of technical quality better than those of functional quality (Panth and Kafle 2018; Mahfouz et al. 2020), especially in developed countries. After reviewing various research works in a global context, it was expected that respondents of this study rated functional quality of services (mean 2.96) less favorably than technical. Among the separate functional quality subscales, communication with medical staff (mean 3.37) and provision of information (mean 3.12) were rated highest, and participation in decision-making (mean 2.84) was rated lowest.

Evaluation of technical quality of services from patients' perspective

When evaluating each of the analyzed aspects of technical quality (Table 4), with the exception of such indicators as hospital food, waiting time in the emergency department (availability of services) and the number of staff in a certain department, the vast majority of respondents evaluated statements defining aspects of technical quality favorably ("agree") and very favorably ("completely agree").

**Table 4.** Evaluation of technical quality indicators from patients' perspectives

| | M | SD | Not evaluated, not applicable | Completely disagree | Partially agree | Agree | Completely agree |
|---|---|---|---|---|---|---|---|
| **TECHNICAL QUALITY** | **3.32** | **0.49** | | | | | |
| **Environment of the maternity unit** | **3.34** | **0.52** | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| The maternity unit has clear instructions (signs) helping patients to orient themselves | 3.39 | 0.62 | 0.0% | 0.0% | 7.6% | 46.3% | 46.1% |
| Facilities enabling free movement in the maternity unit premises, depending on the condition, are provided (elevator, wheelchair, stairs) | 3.48 | 0.51 | 0.0% | 0.0% | 0.7% | 51.2% | 48.1% |
| The maternity unit is equipped with all the necessary treatment and care facilities | 3.48 | 0.51 | 0.0% | 0.0% | 0.7% | 51.6% | 47.8% |
| I am satisfied with the hospital food | 3.01 | 0.73 | 0.0% | 0.7% | 24.2% | 49.9% | 25.2% |
| Arrangement of the premises | 3.40 | 0.53 | | | | | |
| Patients' privacy is ensured (screens, curtains, separate space in the emergency department, maternity wards) | 3.39 | 0.59 | 0.0% | 0.0% | 5.6% | 50.2% | 44.1% |
| Examination equipment and the hospital premises are kept clean | 3.40 | 0.54 | 0.0% | 0.0% | 2.3% | 55.7% | 42.0% |
| Availability of services | 3.11 | 0.62 | | | | | |
| I am satisfied with the waiting time in the emergency department (from arrival to examination) | 2.98 | 0.74 | 0.0% | 0.7% | 26.7% | 47.4% | 25.2% |
| There are enough staff in the department | 3.23 | 0.70 | 0.0% | 0.0% | 14.8% | 46.8% | 38.5% |
| Staff qualification/competence | 3.44 | 0.52 | | | | | |
| The staff (doctors) perform their professional duties perfectly | 3.44 | 0.52 | 0.0% | 0.0% | 1.0% | 54.2% | 44.8% |
| The staff (midwives) perform their professional duties perfectly | 3.43 | 0.52 | 0.0% | 0.0% | 1.3% | 54.6% | 44.1% |

*M – mean; SD – standard deviation.*

It should be emphasized that respondents did not point out the lack of staff as a possible problematic aspect, although the lack of obstetrical staff is noticeable in many maternity units (including the one investigated in this case study). Of course, it is difficult for patients to assess such internal nuances of the institutions' activity during a short hospital stay, and the fact that women in labor do not notice a lack of staff indicates that the available resources in the particular maternity unit are distributed efficiently. It was established that, while assessing the environment of the obstetric unit, provision of the necessary treatment and care facilities along with those ensuring free movement in the unit were rated highest. Analyzing the subscale of the arrangement of the premises, cleanliness of medical equipment and premises (mean 3.40) was rated highest.

While analyzing the results of staff qualification and competence evaluation, no significant difference between the work quality of doctors and midwives was found – 99% of respondents

"agreed" and "completely agreed" with the statement that doctors perform their professional duties perfectly; in the case of midwives, 98.7% of respondents had the same opinion.

### 3.4. Evaluation of functional quality of services from patients' perspectives

In this study, among the subscales of functional quality, patients rated communication with medical staff highest, while participation in decision-making was rated lowest (Table 5). Such findings do not oppose those of other researches, in which decision-making was evaluated poorly or worse compared to other quality indicators (Donate-Manzanares 2019). However, without undermining the importance of patient empowerment in decision-making, taking into account obstetric specifics, it is necessary to evaluate each clinical situation separately. Complex clinical situations need to be kept in mind, and principles such as patient welfare, timeliness of decisions, and benefit/harm assessment need to be taken into account. Patients in certain situations are not able to make an appropriate decision due to the need for specific knowledge or conditions complicating decision-making, which occur quite often in obstetrics.

**Table 5.** Evaluation of functional quality indicators from patients' perspectives

| | M | SD | Not evaluated, not applicable | Completely disagree | Partially agree | Agree | Completely agree |
|---|---|---|---|---|---|---|---|
| **FUNCTIONAL QUALITY** | **2.96** | **0.46** | | | | | |
| **Communication with medical staff** | **3.37** | **0.48** | | | | | |
| Doctors introduced themselves during the first visit and were kind | 3.41 | 0.52 | 0.0% | 0.0% | 1.7% | 56.2% | 42.1% |
| Midwives introduced themselves during the first visit and were kind | 3.42 | 0.53 | 0.0% | 0.0% | 1.7% | 55.6% | 42.8% |
| Doctors were respectful | 3.40 | 0.55 | 0.0% | 0.0% | 3.0% | 54.9% | 42.1% |
| Midwives were respectful | 3.41 | 0.54 | 0.0% | 0.0% | 2.7% | 54.6% | 42.8% |
| Doctors listened to me and did not interrupt me when I spoke | 3.34 | 0.60 | 0.0% | 0.0% | 6.6% | 53.4% | 40.0% |
| Midwives listened to me and did not interrupt me when I spoke | 3.36 | 0.56 | 0.0% | 0.0% | 4.3% | 56.1% | 39.6% |
| The staff took into account the needs of the birth attendant during labor | 3.34 | 0.49 | 10.0% | 0.0% | 0.7% | 59.4% | 30.0% |
| The staff were quick to respond to my complaints and needs during labor | 3.32 | 0.51 | 0.7% | 0.0% | 2.3% | 63.5% | 33.5% |
| Provision of information | 3.12 | 0.55 | | | | | |
| Doctors answered all my questions | 3.07 | 0.72 | 0.0% | 0.0% | 23.2% | 47.1% | 29.7% |
| Midwives answered all my questions | 3.18 | 0.65 | 0.0% | 0.0% | 13.9% | 55.1% | 31.0% |
| I was informed before each examination | 3.36 | 0.57 | 0.0% | 0.0% | 4.6% | 55.7% | 39.6% |
| I was provided with information about the procedures | 3.19 | 0.69 | 0.0% | 0.0% | 16.3% | 49.6% | 34.2% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| I was informed about the steps taken during the procedures | 3.27 | 0.61 | 0.0% | 0.0% | 9.0% | 55.7% | 35.3% |
| I was provided with information about the results of the examinations and procedures | 3.04 | 0.70 | 0.0% | 0.0% | 23.2% | 50.6% | 26.2% |
| I was informed about the possibility of giving birth in different labor positions | 2.61 | 0.80 | 11.6% | 6.6% | 33.2% | 38.5% | 10.1% |
| Participation in decision-making (patient empowerment) | 2.84 | 0.63 | | | | | |
| I was able to take an active role in making decisions about my maternity care | 3.17 | 0.62 | 2.0% | 0.0% | 12.3% | 58.0% | 27.7% |
| I could choose the method of pain relief during labor | 2.82 | 0.72 | 13.3% | 1.3% | 27.7% | 43.9% | 13.8% |
| I could choose to give birth in my preferred labor position | 2.62 | 0.78 | 20.1% | 5.3% | 30.2% | 36.0% | 8.5% |
| It was possible to move freely during labor | 2.52 | 0.87 | 16.9% | 10.6% | 30.3% | 32.3% | 9.8% |
| Staff empathy | 3.01 | 0.49 | | | | | |
| I felt safe during labor | 3.22 | 0.58 | 0.0% | 0.0% | 8.1% | 61.5% | 30.3% |
| Doctors tried to understand my experience during labor | 2.90 | 0.64 | 0.3% | 0.0% | 25.9% | 58.4% | 15.4% |
| Midwives tried to understand my experience during labor | 2.91 | 0.63 | 0.3% | 0.0% | 25.4% | 58.5% | 15.8% |
| Doctors provided emotional support during labor | 2.96 | 0.58 | 0.3% | 0.0% | 18.6% | 66.2% | 14.9% |
| Midwives provided emotional support during labor | 3.03 | 0.54 | 0.3% | 0.0% | 12.8% | 70.6% | 16.3% |

Women participating in this study rated communication with midwives slightly better than with doctors, but this difference was minimal. In general, over 93% of respondents evaluated communication with medical staff favorably ("agreed" and "completely agreed"), which leads to the conclusion that the situation in Lithuanian maternity units is better than observed on a global scale. For comparison, according to a study conducted in Poland, when assessing the aspects of communication between the patient and the staff, in 25% of cases inappropriate comments of staff towards pregnant women were reported (Baranowska et al. 2019). In Asian countries, according to various studies, verbal disrespectful communication is even more common – although the majority of women indicated that services were provided with respect, disrespectful behavior such as shouting (30%) and a lack of positive communication regarding pain relief (28%) was reported (Pathak and Ghimire 2020). In developing countries, the lack of respect in communication between women in labor and doctors is even more relevant, which is why some women even avoid giving birth in healthcare facilities (Okonofua et al. 2017).

Provision of information is another problematic aspect that often leads to patient dissatisfac-

tion with the quality of services. In this study, although women rated provision of information before examinations highest in this particular subscale, the worst score on the entire functional quality scale (mean 2.61) was assigned to the provision of information about the possibility to choose different labor positions. Regarding this possibility, 6.6% of the respondents completely disagreed that they were adequately informed, and 33.2% only partially agreed with the statement. It should be mentioned that the answer "I do not evaluate/it did not apply to me" was marked by women who gave birth surgically (most often via planned C-section, less often via urgent C-section), in which case providing such information makes no difference. Also, 23.2% of respondents only partially agreed that they were informed about the results of examinations and procedures. Such a score, taking into account the principle of fully informed consent, is more than high enough. These results presuppose that patients (in this case pregnant women) must actively ask staff about possible labor positions themselves and take an active interest in the results of their examinations. However, the principle of effective communication, especially taking into account the possible complexity of both the physical and psychological condition of women during labor, would be implemented only if the staff ensured the better awareness of the pregnant women on their own initiative. Of course, as mentioned before, it is necessary to evaluate the specific clinical situation, but the provision of information remains mandatory. Since fully informed consent as well as the ability to make decisions related to one's healthcare are emphasized in the twelve principles of respectful maternity care, these results should be taken into account when communicating with pregnant women as this would contribute to improving the quality of services.

When analyzing the worst rated aspect of the functional quality of services scale – participation in decision-making – we can see that women rated participation in decision-making quite well in general (mean 3.17). However, other statements were rated poorly (Table 5). Unfortunately, analyzing this aspect, it is especially important to take into account the clinical picture in each case, because the situation may not allow free movement during labor or giving birth in the desired labor position, even if the patient insists on it. The communication skills of the staff and the ability to clearly, patiently, and respectfully provide women with detailed information on why certain actions are impossible due to certain risk conditions for mother or fetus could and should help here. When maintaining necessary communication with women in such situations, it is imperative that women are actively included in the healthcare process, which would ensure the much-desired participation of pregnant women in decision-making by itself, and would allow dissatisfaction which may be caused by not meeting certain expectations related to the course of labor to be avoided. It should always be kept in mind when communicating with not only women in labor but also with patients in general that this research aspect is extremely important for them, because, as indicated in this study, most patients (95.2%) wanted to be the main decision makers in the healthcare process (Vedam et al. 2019).

The final investigated aspect of functional quality – staff empathy – is no less significant for patients, especially in obstetrics, and is often one of the final determinants of the quality of services received. Staff empathy is necessary to ensure effective communication between women in labor and doctors/midwives. According to this study, the feeling of safety during labor was evaluated highest. Women rated the level of empathy of doctors somewhat worse than of midwives (Table 5). A quarter of women participating in the study only partially agreed that both doctors and midwives try to understand what they experience during labor. As in other cases, when evaluating respondents' answers, the psychological state of each woman should be kept in mind, especially in the later stages of labor. The impact of pain on the evaluation of the quality of services must

also be taken into account, because the more pain a woman in labor experiences, and the longer the recovery period lasts, the more it affects satisfaction with the quality of services (Lippke at al. 2019). As a result, the assessment of the level of empathy experienced is extremely subjective; therefore, in order to achieve more reliable results, it is necessary to study the correlations with pain relief and factors of the postpartum period.

### 3.5. Evaluation of external effectiveness from patients' perspectives

In patient surveys, this indicator is usually one of the most important, as it indicates the overall level of patient satisfaction with the services and summarizes patients' experiences at the health facility. According to this study, 90.8% of respondents would recommend the obstetrics department of the investigated medical institution to a close acquaintance. Slightly fewer respondents would choose the same facility for their next birth, with 87.7% of respondents "agreeing" and "completely agreeing" with this statement (Table 6).

**Table 6.** Evaluation of external effectiveness from patients' perspectives

| | M | SD | Not evaluated, not applicable | Completely disagree | Partially agree | Agree | Completely agrees |
|---|---|---|---|---|---|---|---|
| **EXTERNAL EFECTIVENESS** | **3.55** | **0.51** | | | | | |
| I am satisfied with the work quality of doctors in this maternity unit | 3.59 | 0.51 | 0.0% | 0.0% | 0.7% | 40.3% | 59.0% |
| I am satisfied with the work quality of midwives in this maternity unit | 3.58 | 0.51 | 0.0% | 0.0% | 1.0% | 40.3% | 58.7% |
| I am satisfied with the services in this maternity unit | 3.61 | 0.52 | 0.3% | 0.0% | 1.7% | 36.0% | 62.0% |
| The quality of services in this maternity unit is high | 3.66 | 0.49 | 0.0% | 0.0% | 0.7% | 32.3% | 67.0% |
| I would choose this maternity unit for my next childbirth | 3.42 | 0.70 | 0.0% | 0.0% | 12.3% | 32.8% | 54.9% |
| I would recommend this maternity unit to my relatives/friends | 3.46 | 0.66 | 0.0% | 0.0% | 9.3% | 35.2% | 55.6% |

The quality of the services at the maternity unit were rated highly by 99.3% of participants. Over 99% of respondents were also satisfied with the work of both doctors and midwives. Slightly more women reported higher satisfaction with the services provided by midwives.

### 3.6. The significance of specific factors affecting assessment when evaluating the quality of services

Assessment of the quality of services can be influenced by both factors directly (mode of delivery, duration of pregnancy, method of pain relief) and not directly (age of pregnant woman, various social factors) related to pregnancy and labor. For this research, factors that can be objectively assessed, that are analyzed in other scientific sources (providing the possibility of comparative analysis), and that are important for ensuring respectful maternity care were selected.

### 3.6.1. The influence of socio-demographic factors on the assessment of the quality of services

The results of studies examining the influence of socio-demographic factors on satisfaction with the quality of obstetric services are contradictory. Panth and Kafle (2018) found no statistically significant differences between women's satisfaction with the quality of maternity services and socio-demographic factors. Similarly, no differences were found in research conducted on the Italian population by Fumagalli et al. (2021), with a sample of 277 women. In contrast, other research also conducted on the Italian population revealed that although age did not affect satisfaction, more highly educated women reported higher satisfaction with quality of services (Tocchioni et al. 2018). In this study, no significant differences between women's age, marital status, and education level were detected.

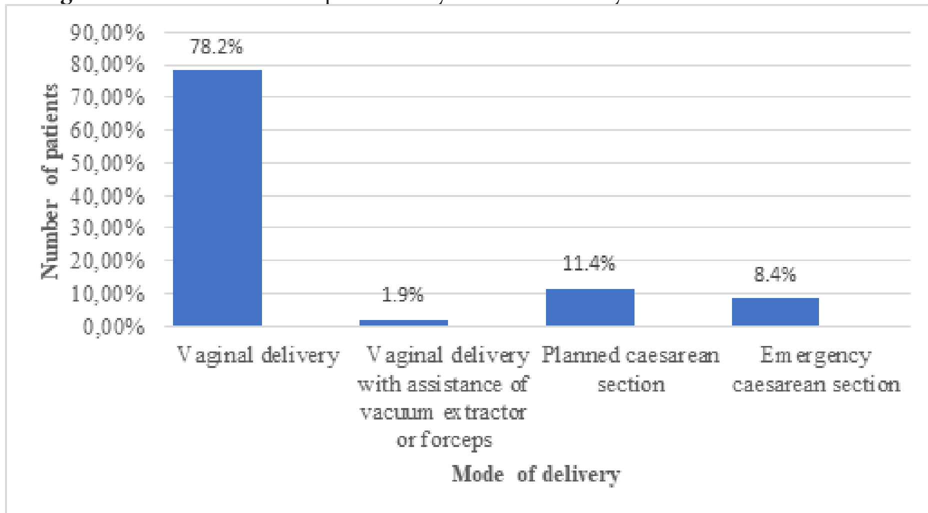
### 3.6.2. The influence of the number of pregnancies on service quality assessment

Among the women who participated in the study, 61.5% were pregnant for the first time, while 38.5% had had multiple pregnancies. According to the study of Fumagalli et al. (2021), women who were pregnant for the second time or more were more satisfied with the quality of services. Pathak and Ghimire (2020) found that women who had had multiple pregnancies reported receiving more timely care and were treated with more respect during labor. Women who were pregnant for the second time or more were also more satisfied with the quality of services according to a study conducted by Panth and Kafle (2018), although research results are also contradictory in this regard. Tocchioni et al. (2018), for example, found no significant correlation between the number of pregnancies and satisfaction with the quality of services. In this study, a statistically significant correlation between the number of pregnancies and the assessment of the quality of services was not observed.

### 3.6.3. The impact of mode of delivery on the assessment of the quality of services

In this study, the majority of respondents underwent vaginal delivery (80.1%), of which in 1.9% of cases labor was terminated using instrumental labor assistance. C-sections occurred in 19.8% of the sample (Figure 2).

**Figure 2.** Distribution of respondents by mode of delivery




The results of this study show that women who underwent a planned C-section evaluated the qualifications and competence of the staff (aspects of technical quality), the provision of information, participation in decision-making, and staff empathy (aspects of functional quality) significantly higher than those who gave birth by other modes of delivery (Table 7).

**Table 7.** Satisfaction with the quality of services according to the mode of delivery

| | Mode of delivery | | | | | | | | H | p |
|---|---|---|---|---|---|---|---|---|---|---|
| | Vaginal delivery | | Vaginal delivery with the assistance of a vacuum extractor or forceps | | Planned caesarean section | | Emergency caesarean section | | | |
| | M | SD | M | SD | M | SD | M | SD | | |
| TECHNICAL QUALITY | 3.30 | 0.48 | 3.26 | 0.71 | 3.53 | 0.50 | 3.23 | 0.45 | 6.899 | 0.075 |
| Environment of the health facility | 3.32 | 0.52 | 3.38 | 0.70 | 3.50 | 0.54 | 3.28 | 0.47 | 3.514 | 0.319 |
| Arrangement of the premises | 3.39 | 0.53 | 3.33 | 0.75 | 3.57 | 0.53 | 3.31 | 0.49 | 4.621 | 0.202 |
| Availability of services | 3.08 | 0.61 | 2.83 | 0.93 | 3.37 | 0.62 | 3.02 | 0.56 | 7.541 | 0.057 |
| Staff qualification/competence | 3.41 | 0.52 | 3.50 | 0.55 | 3.66 | 0.48 | 3.33 | 0.47 | 8.118 | 0.044 |
| FUNCTIONAL QUALITY | 3.04 | 0.44 | 2.88 | 0.71 | 2.61 | 0.32 | 2.63 | 0.39 | 43.628 | 0.000 |
| Communication with medical staff | 3.37 | 0.47 | 3.34 | 0.76 | 3.54 | 0.45 | 3.23 | 0.48 | 7.350 | 0.062 |
| Provision of information | 3.06 | 0.53 | 2.95 | 0.87 | 3.51 | 0.52 | 3.09 | 0.53 | 20.719 | 0.000 |
| Participation in decision-making (patient empowerment) | 2.80 | 0.63 | 2.50 | 0.59 | 3.30 | 0.53 | 2.67 | 0.49 | 18.752 | 0.000 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Staff empathy | 2.98 | 0.49 | 2.83 | 0.63 | 3.28 | 0.49 | 2.90 | 0.41 | 12.975 | 0.005 |
| EXTERNAL EFFECTIVENESS | 3.52 | 0.52 | 3.56 | 0.70 | 3.73 | 0.44 | 3.62 | 0.48 | 6.061 | 0.109 |

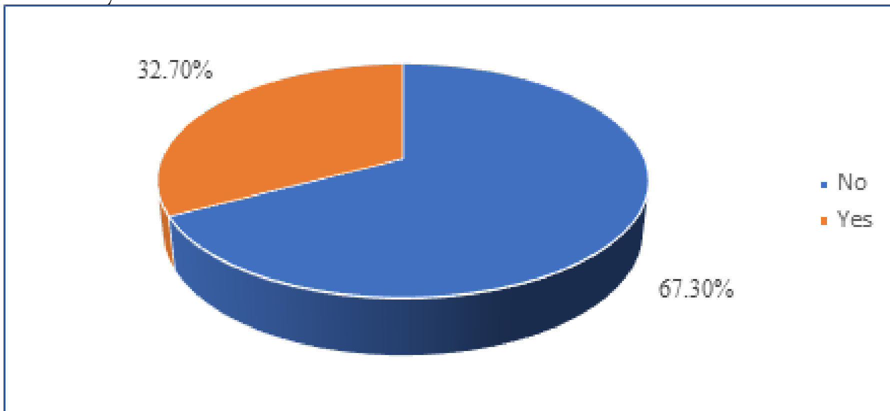
*H – Kruskal–Wallis H test; $p < 0.05$.*

A more positive assessment of functional quality and its individual aspects among women who had a planned C-section can be caused by psychological factors related to childbirth and its course. Women who are expected to have a planned C-section know the date of delivery in advance. Often, they have met the doctor performing the surgery during previous appointments and they clearly know the indications for surgical delivery. Therefore, compared to other groups of pregnant women, they are more likely to experience less anxiety and feelings of uncertainty before and during labor, which also leads to a more positive assessment of functional quality.

### 3.6.4. The impact of birth canal condition after labor on the assessment of the quality of services

In this study, perineal injuries (both episiotomy and rupture) were observed in 32.7% of cases (Figure 3). The frequency of episiotomy varies worldwide – 8% in the Netherlands, 14% in Great Britain, 50% in the USA – and in 14.9% of cases the incision tears further than the length of the cut (*Metodika*, 2019). We can see that this particular procedure is performed quite often in obstetrics, so it is necessary to determine its impact on the assessment of the quality of services.

**Figure 3.** Distribution of respondents according to the frequency of perineal injuries during vaginal delivery




Women who did not experience perineal injuries evaluated the general functional quality and communication with the medical staff significantly more positively compared to those who had perineal injuries during labor (Table 8).

**Table 8.** Satisfaction with the quality of services according to the frequency of perineal injuries among women who underwent vaginal delivery

| | In case of vaginal delivery, were there any injuries to the birth canal? | | | | *U* | *p* |
|---|---|---|---|---|---|---|
| | No | | Yes | | | |
| | *M* | *SD* | *M* | *SD* | | |
| TECHNICAL QUALITY | 3.32 | 0.48 | 3.27 | 0.49 | 6943.0 | 0.434 |
| Environment of the maternity unit | 3.33 | 0.53 | 3.31 | 0.52 | 7182.5 | 0.723 |
| Arrangement of the premises | 3.37 | 0.55 | 3.40 | 0.52 | 7205.0 | 0.740 |
| Availability of services | 3.13 | 0.58 | 3.00 | 0.65 | 6559.0 | 0.128 |
| Staff qualification/competence | 3.46 | 0.50 | 3.36 | 0.54 | 6786.5 | 0.221 |
| FUNCTIONAL QUALITY | 3.09 | 0.40 | 2.97 | 0.50 | 6190.5 | 0.032 |
| Communication with medical staff | 3.42 | 0.45 | 3.29 | 0.50 | 6251.0 | 0.034 |
| Provision of information | 3.12 | 0.52 | 2.97 | 0.56 | 6183.0 | 0.030 |
| Participation in decision-making (patient empowerment) | 2.85 | 0.59 | 2.72 | 0.68 | 6331.5 | 0.056 |
| Staff empathy | 2.99 | 0.47 | 2.95 | 0.52 | 6921.0 | 0.402 |
| EXTERNAL EFFECTIVENESS | 3.57 | 0.50 | 3.45 | 0.55 | 6387.5 | 0.057 |

*U – Mann–Whitney U criteria; $p < 0.05$.*

It can be expected that pain and discomfort after labor associated with perineal injuries and certain restrictions after an episiotomy in order to speed up the healing process of the wound might undoubtedly lead to a less favorable quality assessment, taking into account the psychological and physical discomfort suffered. Fumagalli et al. (2021) also found that women who did not have labor-related perineal injuries evaluated the quality of services more positively. It should be remembered, however, that the very fact of tearing or cutting of the perineum is determined by the incongruity between perineal tissue elasticity and fetal body dimensions, so it does not by itself correlate with the quality of services, especially functional ones.

#### 3.6.5. The impact of ensuring an early bond between mother and child immediately after delivery on the assessment of the quality of services

According to this study, the newborn was placed on the mother's chest immediately after birth in 75% of cases. After analyzing the results, it was found that the general functional quality was evaluated significantly more positively by women who had their newborn placed on their chest, compared to those who were not provided with this opportunity. Therefore, there is a need to improve communication between staff and pregnant women in order to reduce dissatisfaction with the quality of services related to the lack of early contact between mother and newborn, assuming that in all cases contact was limited because of medical reasons. It should be noted that studies on the impact of these certain circumstances on satisfaction with the quality of services

could not be found. Therefore, the importance of this aspect and its impact on the satisfaction with services should be included in research conducted in the future.

## 4. Conclusions

1. This study revealed that technical quality of services was rated better than functional quality by women who gave birth. Of the functional quality subscales, the level of participation in decision-making was rated lowest, and this data does not oppose the results published by other authors. The growing role of patients as independent participants in the healthcare system determines the increasing need for patients to be actively engaged in all stages of their treatment process.

2. During this research, the importance of such universal aspects of healthcare as the fully informed consent of the patient, which is necessary for effective communication, and enabling the patient to participate in decision-making were highlighted. Participation in decision making was evaluated poorly in this study compared to other analyzed indicators, although evaluation was quite positive in the global context. These mentioned aspects should be guaranteed by staff on all occasions, as their provision is necessary for the implementation of the principles of respectful maternity care established by the WHO. Moreover, they are essential in order to improve the quality of maternity services in general.

3. This research allowed for the identification of groups of women who, given the circumstances, would probably rate the quality of services, especially functional ones, poorly. These are women who underwent vaginal delivery, women who had an episiotomy, and women who were not granted early contact with their newborn immediately after giving birth. Another important aspect is the likelihood of these groups of women to evaluate the quality of services more positively if they were more satisfied with the communication between themselves and the staff providing services. However, the impact of effective communication on the groups of women mentioned earlier should be further investigated.

4. Considering the great importance of subjective factors in the evaluation of the quality of services and with the emergence of new guidelines defining the quality of care, it is obvious that standard quality assessment questionnaires for assessing the quality of obstetric services do not provide sufficiently accurate information about the quality of services provided. Quality assessment questionnaires intended for obstetric facility units must be revised and supplemented with questions focused on obstetric specifics.

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## PACIENČIŲ POŽIŪRIS Į AKUŠERINIŲ PASLAUGŲ KOKYBĘ TRETINIO LYGIO AKUŠERINES PASLAUGAS TEIKIANČIAME STACIONARE

**Anotacija.** *Augantis paciento kaip pagrindinio paslaugų kokybės vertintojo vaidmens pripažinimas kokybės gerinimo procese ir nuolatinis neigiamos gimdymo patirties (būklės, susijusios su neigiama patirtimi, pvz., pogimdyminė depresija ar kitokia našta) eskalavimas žiniasklaidoje tiek atskiriems individams, tiek visuomenei skatina plačiau nagrinėti su akušerinių paslaugų teikimo kokybe susijusius, ją formuojančius aspektus. Akušerinių paslaugų sektoriaus vaidmuo pabrėžiamas Lietuvos sveikatos programoje, kurioje numatomos ilgalaikės gimdyvėms teikiamų paslaugų kokybės tobulinimo kryptys. Akušerinių paslaugų kokybės užtikrinimo tematika yra viena prioritetinių Pasaulio sveikatos organizacijos veiklos krypčių. Šio tyrimo tikslas – įvertinti pacienčių (gimdyvių) požiūrį į teikiamų akušerinių paslaugų kokybę. Tretinio lygio akušerines paslaugas teikiančioje sveikatos priežiūros įstaigoje buvo atliktas kiekybinis anketinės apklausos tyrimas. Tyrime dalyvavo 309 pagimdžiusios moterys, joms pateikta 50 klausimų paslaugų kokybės vertinimo anketa. Suminis vidinis klausimyno patikimumas – 0,966. Nustatyta, kad nors tiriamos įstaigos paslaugų kokybė vertinama kaip aukšta, tačiau moterų poreikis aktyviai dalyvauti savo sveikatos priežiūros procese realizuojamas nepakankamai, tobulintini komunikaciniai paslaugų teikimo aspektai. Išskirtos pa-*

*cienčių grupės, kurių priežiūrai, siekiant gerinti teikiamų paslaugų kokybę iš paciento perspektyvos, skirtinas ypatingas personalo dėmesys, pirmiausia realizuojant efektyvios komunikacijos tarp paciento ir paslaugas teikiančio personalo poreikį. Tai natūraliais gimdymo takais gimdžiusios moterys, kurioms atlikta epiziotomija, ir moterys, kurioms nebuvo užtikrintas ankstyvas kontaktas su naujagimiu iškart pagimdžius. Vertinant greitą paslaugų kokybę apibūdinančių veiksnių kaitą, atsirandant naujų kokybišką paslaugų teikimą apibrėžiančių faktorių, tampa akivaizdu, kad standartinės kokybės vertinimo anketos, skirtos vertinti akušerinių situacijų paslaugų kokybei, turi būti nuolat atnaujinamos, o kokybės vertinimas turi būti atliekamas periodiškai, pasitelkus vertinimo klausimynus, orientuotus į akušerijos kokybės specifiką.*

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