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**Asking women to complete health and maternal histories for maternity records:  
A qualitative study of women and staff in Scotland.**

**Patricia E Aitchison<sup>1</sup>, Vikki A Entwistle<sup>1</sup>, Edwin van Teijlingen<sup>2</sup>, Heather M Whitford<sup>1</sup>, Tracey Davidson<sup>3</sup>, Tracy Humphrey<sup>3,4</sup>, Janet S Tucker<sup>3</sup>**

**Institutional affiliation at time of study:**

1. University of Dundee
2. Bournemouth University
3. University of Aberdeen
4. NHS Grampian

**Current appointments**

Patricia E Aitchison: Research Fellow, University of Stirling

Vikki A Entwistle: Professor of Health Services Research and Ethics, University of Aberdeen

Edwin van Teijlingen: Professor of Reproductive Health Research, Bournemouth University

Heather M Whitford: Lecturer, University of Dundee

Tracey Davidson: Trial Manager, University of Aberdeen

Tracy Humphrey: Professor of Midwifery, Robert Gordon University; Consultant Midwife, NHS Grampian

Janet S Tucker: Honorary Senior Research Fellow, University of Aberdeen

**Corresponding author: Vikki Entwistle ([Vikki.entwistle@abdn.ac.uk](mailto:Vikki.entwistle@abdn.ac.uk))**

## **Asking women to complete health and maternal histories for maternity records: A qualitative study of women and staff in Scotland.**

### **Abstract**

Midwives usually document women's health and maternal histories during booking appointments. This qualitative study of use of the Scottish Woman Held Maternity Record (SWHMR) found some midwifery teams were asking women to document their own histories before these appointments. Pregnant women and midwives from these teams thought this could save midwives' time, improve the accuracy of records and lead to more individually-appropriate discussions. However, some women were disappointed that midwives had not fully discussed what they had written. Some midwives from teams that had not asked women to document their own histories were sceptical about the likely accuracy and usefulness of women's entries.

If the potential advantages of asking women to document their own histories are to be safely realised, support must be available for women with limited English or reading and writing skills, and midwives must have time to review and discuss what women write.

**(146 words)**

### **Key phrases**

Midwives conventionally document women's health and maternal histories while asking a series of questions during booking appointments.

Some midwifery teams have asked women to complete their own health and maternal histories in woman-held records.

This can save time during booking appointments and allow midwives and women to focus on the topics that are most relevant to the individuals concerned.

However, some women need support to document their histories, and it is important that midwives review and discuss what women have written.

### **Key Words**

Maternity care, Medical records, Patient participation, Professional-patient relations, Safety.

## **Introduction**

Many maternity services now ask pregnant women to carry their own maternity records. This can help ensure the records are available to all professionals involved in managing a woman's pregnancy (Lovell et al, 1987; Bedford and Chambers, 2003). It can also support women's active engagement in their care (Rowe et al, 2002; Brown and Smith, 2011).

The Scottish Woman Held Maternity Record (SWHMR) was implemented across Scotland in 2007 (NHS Healthcare Improvement Scotland, 2011a). One innovative feature of the SWHMR is that women are invited to write in it. A pencil symbol indicates places for women to note future appointments and any questions they want to ask, and to express preferences, particularly about labour and birth options. Few women write in these sections (Craig et al, 2010; Humphrey et al, 2013), but it is unclear why.

## **Aim and focus**

A qualitative study was conducted in two Scottish regions to explore women's and health professionals' experiences with the SWHMR, and particularly of opportunities for women to write in it (Entwistle et al, 2009).

This paper focuses only on experiences of documenting women's health and maternal histories. These sections of the SWHMR were not designed to be completed by women, but some maternity care teams were asking women to complete them.

## **Methods**

The study used semi-structured face-to-face interviews (Bowling, 1997) and methods were approved by the North of Scotland Research Ethics Committee

### **Sampling and recruitment**

Study midwives identified women who were about 32 weeks pregnant and sent them an invitation to participate. Purposive sampling (Forrest and van Teijlingen, 2004) ensured a diverse range of women were included. Researchers met women at antenatal clinics and arranged interviews if women chose to participate. Women who completed an antenatal interview were asked to give a second, postnatal interview once their baby was six weeks old.

A diverse sample of professionals (midwives working in community-based services and hospitals, obstetricians and general practitioners (GPs)) were recruited via senior midwives and GP networks.

## **Data collection**

Researchers had topic guides but conducted the interviews conversationally. Interviews lasted about 30 minutes and all were audio-recorded and transcribed.

## **Data analysis**

The research team read and discussed a diverse sample of interview transcripts before developing a set of chart headings that reflected project aims and points raised during interviews. Interview data were then summarised systematically under the chart headings to facilitate further analytic discussion (Ritchie et al, 2003).

Quotations below are labelled with: A or B to indicate study regions; W (woman using maternity service), M (midwife), O (obstetrician) or GP to indicate participant type; and an identifier number. Three dots (...) indicate where quotations have been shortened.

## **Findings**

Forty two women gave antenatal interviews of which 29 also completed postnatal interviews (Table 1). Twenty four health professionals participated (Table 2).

**[insert Table 1]**

**[insert Table 2]**

## **Approaches to completing health and maternal histories**

Midwifery teams from the two regions varied in terms of when and how they gave women their records and documented health and maternal histories. Table 3 summarises the three main approaches.

**[insert Table 3]**

In Region A, women were asked to complete history sections at home before their booking appointment. In most areas of Region B, midwives completed these sections conventionally during booking appointments. In some areas of Region B, however, midwifery teams asked women to fill out their histories themselves when they arrived for their booking appointment.

### ***Women's experiences of completing health and maternal histories***

Most women from Region A found completing the history sections fairly straightforward.

I think in our modern society when you're so used to filling in paperwork for anything ... it was easily done, I did it in my tea break at work. (AW47)

You just tick a few boxes and it's quite straightforward for your midwife to see.  
(AW52)

Some women had asked family members for information.

It [record] asks about your partner ... obviously just checking things with him about that 'cause I don't know all his family history off the top of my head.  
(AW29)

When I was calling my mum, "Did you have any problems in pregnancy?"  
(AW30)

Some immigrant women reported difficulties due to their limited English (especially pregnancy-related terminology and writing). They described asking partners or family members for help.

I asked my husband ... so he helped me with it, so he's tried to explain it to me and we fill it in together. (AW48)

He [husband] explained to me and I told him "yes" or "no" and he just write it.  
(AW82)

Most women who completed their own health and maternal histories recalled 'checking' and discussing these with their midwife during the booking appointment.

Women from Region B who had been asked to fill in their histories immediately before their booking appointment mostly found this straightforward. Some, however, had felt put-on-the-spot with the task. One, who had not told her midwife she was dyslexic, had become quite anxious.

It felt like a test. It felt like being back at school again. I didn't like it because it made me feel a bit stupid, because I was scared in case I spelt the words wrong. (BW47)

None of the women who had documented their histories on clinic premises mentioned contacting family members for information (apart from partners who were at the clinic with them).

Midwives from both regions said it was important to review and discuss what women had written, and several saw this as a key opportunity to provide information and explore women's concerns. Some women from both regions, however, expressed disappointment that midwives had not adequately discussed the issues they had documented in their history sections.

I know that it is just your personal information and that's fine because it's probably easier for you to fill it in than them, but I've got quite a lot of medical problems so it would have been quite nice to have gone through that with someone so that they were aware. (BW46)

Women from Region B whose midwives had documented their health and maternal histories during booking appointments in the conventional way apparently accepted this approach as routine.

[At booking the midwife] went through this questionnaire and asked me all these questions and covered everything in there. (BW21)

At the booking-in appointment there was lots of check-box ticking which went very fast. (BW39)

### ***Use of antenatal clinic time***

Women from Region A consistently appreciated that by filling in their histories at home they could save time in booking appointments and have more useful discussions with their midwife.

I think with the demands on the health service if you can fill in something at home that will take less time, you know, rather than having a forty five minute appointment where you're just filling in bits of paperwork, it makes a lot more sense to do it at home. (AW47)

It probably saves a lot of time too with things that don't need discussing. (AW79)

Midwives also thought it could be 'a big help' (AM4) if women completed these before their booking appointments.

The potential to save time during booking appointments had generated some interest among midwifery teams in Region B who were not currently asking women to complete their own history sections.

One of the things that we're looking at ... is that the women could actually be filling in part of the notes themselves ... because there's some stuff which is very time-consuming. (BM39)

### ***Completeness of information obtained***

Staff in Region A thought that most women completed their history sections reasonably well. They acknowledged that women with poor English or limited reading or writing skills could struggle, but said that these women either got help from family or left forms blank.

Some staff from Region A suggested that women found it easier to disclose sensitive information if they completed their own health and maternal histories.

If there's sensitive things, you know, to do with family history and things, they can write it down themselves without having to discuss it then and there with a midwife (AM21)

I think that women are much more willing to write down that they've suffered from depression or anxiety or something in the past and that they might be willing to accept additional assistance than they would be willing to volunteer that verbally. (AO26)

Midwives in Region B who had no experience of women completing their own histories were mostly sceptical when asked about it hypothetically. Several suggested that the conventional approach was most effective for obtaining comprehensive and accurate histories, and for building rapport with women.

I know from my experience, most of my women wouldn't be able to fill that out or they'd be frightened to fill it out, because they'd be frightened they'd make a mess of it, or they wouldn't understand, you know. (BM47)

[At a booking appointment] it's not the first time I've actually quoted from the GP letter and [the woman has] said "That's not me", so, you know, it breaks down barriers and it gets you to chat with the woman and their partners. (BM33)

One community midwife in Region B, however, also illustrated the challenges of obtaining accurate information from women around sensitive issues during booking appointments, especially with partners present:

[You ask] "Have you ever used any street drug?" and you can see somebody going "No" and then you take them [aside] and then [they say] "Well I did, I used...", but some of them won't tell you anything. That's quite hard ... you've got to try and work it out. (BM34)

### ***Women's writing as a useful source of information***

Several health professionals in Region A indicated that women's writing could provide insights beyond the explicit content of answers to questions. An incomplete or poorly

completed history section could alert staff to reading, writing and comprehension difficulties and encourage them to be sensitive to these.

Because they're filling in their own records you are maybe finding girls who are having difficulty with writing forms and, whereas before I would never realised that, you know, maybe not have sensed it quite as much. (AM6)

Sometimes you'll get girls who've come in with absolutely nothing written in their notes and you do sort of think "Oh gosh", you know, "Can they read and write?". (AM4)

Some professionals said that reviewing these sections before consultations could give them a useful impression of women's personal backgrounds and understanding of pregnancy-related issues. However, poorly completed histories could perhaps be misinterpreted as reflecting women's poor attitudes towards their pregnancy and antenatal care.

It's very rare that they don't complete all the past medical history and past obstetric history and, to be honest, if someone, a patient of mine, didn't complete that I'd be quite worried about them, I'd be concerned about the lack of inclination they felt towards their pregnancy. (AO26)

## **Discussion**

This study included the first investigation of women documenting their own health and maternal histories in a formal maternity record. The study had several strengths, in that it explored women's and professionals' perspectives, and considered women's postnatal as well as antenatal views. Participant samples were diverse, and interviews flexible, so a range of experiences was identified. The main limitations of the study were its reliance on interviews without formal observations of practice, and its inability, as a qualitative study, to provide information about the frequency of particular experiences.

The main finding was that both women and midwives saw benefits of women completing their own health and maternal histories, particularly if women were given time to do this at home and could use family members as sources of information and support. The practice can enable women to gather accurate information, save time and allow communication during appointments to focus on personally relevant issues. Although participants did not explicitly mention it, an invitation to document their histories could also (if appropriately introduced) recognise women as legitimate contributors to their care, provide an early opportunity for women to mention and discuss their particular concerns and preferences, and permit and encourage women's engagement with their records from an early stage.

Inviting women to document their histories is consistent with policies encouraging people's involvement in their own healthcare (Coulter, 2011).

The key concern expressed by professionals related to women with limited English or reading and writing skills. Some women might be reluctant to disclose literacy problems, because of the stigma of low literacy (Easton et al, 2013). This can make it hard for staff to identify and address support needs. Although offering women the option to fill in their own health and maternal histories can, if done sensitively, alert staff to literacy or other difficulties and prompt the mobilisation of appropriate support, the practice also risks imprecise judgements by staff on the basis of women's writing.

The findings tend to be at odds with current guidance, which recommends that maternal history-taking should be midwife-led wherever possible (NHS Quality Improvement Scotland, 2008; NHS Healthcare Improvement Scotland, 2011b). In Region A, a retrospective review of 300 maternal case notes found that substance misuse and domestic violence were sometimes not documented even when they were evident in GP or hospital records, and in some instances, non-documentation of salient maternal history had impacted on care safety (Humphrey et al., 2013). This, together with current guidance, contributed to a recent decision by Region A to stop the practice of asking women to complete their own health and maternal histories.

The potential advantages of inviting women to document their own histories (for engaging women actively in their care, and for efficient use of midwife-woman contact time) must be considered in the light of potential disadvantages (for ensuring healthcare safety). However, efforts to ensure the potential advantages of the approach are more consistently realised could also address the safety concerns.

The main safety concern is the availability of all relevant information for maternity care planning. Midwives recognised that women were sometimes reluctant to disclose sensitive information, for example about drug use, but this could be an issue both in face-to-face consultations as well as when women documented their own histories.

Women may not want information about previous pregnancies included in a maternity record that could be seen by family members and (new) partners for fear of breaches of confidentiality and possible adverse implications of disclosure (Woo et al., 2005; Shellenberg et al., 2011). Midwives in this study described how the SWHMR makes provision, if women prefer, for documenting such information not on the hand held section but on the separate

'Maternity Summary Sheet' held by the community midwife. Women in our study did not mention this facility, however, and it is unclear whether they were routinely made aware of this option. Alerting women to this option for recording sensitive information might help promote full disclosure whether women or midwives lead the initial documentation stage.

The effectiveness of both face-to-face and written data collection methods can vary according to populations, clinical setting and type of information being sought (Reddy et al, 2006; Kim et al, 2008). Both women and midwives, in this study, stressed the importance of health professionals reviewing in a sensitive, non-judgemental and responsive way what women had written in their histories.. Such a process could contribute to the quality of relationship and encourage women to trust and feel trusted (Jourard, 1971; Entwistle and Quick, 2006). Careful checks of what might not have been written could also reduce the likelihood of salient information being withheld.

None of the women who participated in this study mentioned omitting, either in writing or in discussions with midwives, anything that was important to their care, but researchers did not ask about this specifically and it is unclear what women would have considered salient and why. Some non-disclosure of relevant information might be reduced if staff told women *why* information about previous pregnancies, health behaviours and medical history could be important to ensure appropriate care.

### **Implications for practice**

The study identified important, potential advantages and disadvantages of inviting women to document their own health and maternal histories in their records. It also identified some supporting practices that could help ensure the potential advantages are safely realised.

Current guidance recommends that midwives should lead the documentation of health and maternal histories (NHS Quality Improvement Scotland, 2008; NHS Healthcare Improvement Scotland, 2011b). In part, this reflects concerns about the accuracy of what women would write for themselves. However, policies promoting people's involvement in their own care (Scottish Government, 2010) and mounting pressures on staff time suggest maternity services might usefully review the possibility of inviting women to contribute directly to this documentation at home. Safety could be improved by ensuring that midwives explicitly encourage women to complete these sections and explain what information is important and why. Disclosure could also be facilitated by offering women an option to avoid including sensitive information in their woman-held record that could be seen by family, but to share it separately with midwives. Women's experiences and the accuracy of their histories could be improved by ensuring the sections are appropriately designed for completion by women, and

providing suitable support for women with limited English or reading and writing skills. Staff should carefully verify and respond to women's self-documented histories.

All these features should help ensure that health professionals have information relevant to safe care planning and women have opportunities during consultations to discuss their concerns.

(2879)

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## **Authors' Conflicts of interest**

None

**Table 1: Characteristics of study participants (women)**

	<b>Participants (Women) n=42</b>
<b>Age</b>	
< 20 years	3
20-35 years	29
> 35 years	10
<b>Place of residence: maternity service classification</b>	
Urban (<30 minutes drive from regional maternity hospital)	23
Rural (>30 minutes drive from regional maternity hospital)	19
<b>Place of residence: Scottish Index of Multiple Deprivation: 2009 v2 quintiles</b>	
1 (most deprived)	5
2	7
3	6
4	10
5 (least deprived)	9
Unknown due to insufficient postcode data	5
<b>Nationality/country of birth</b>	
United Kingdom	34
Other European Union (non-UK)	2
Outside European Union	6
<b>Parity</b>	
Primiparous (first child)	16
Multiparous (at least one previous pregnancy)	26
<b>Obstetric risk factors</b>	
Age >40 <sup>1</sup>	3
Other medical or obstetric risk factors known during antenatal period (from records or self-reported during interviews) <sup>1</sup>	26
No known risk factors	14
<b>Model of care</b>	
Midwife-led	14

Shared care (at least one visit to consultant clinic before prenatal interview)	28
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<sup>1</sup>One woman >40 had other medical or obstetric risk factors too

**Table 2: Characteristics of study participants (health professionals)**

	<b>Participants (Staff) n=24</b>
<b>Midwives</b>	15
<b>Current work base</b>	
Hospital	6
Community and/or midwife-led unit	9
<b>Years since qualification</b>	
<10 years	1
10 or more years	14
<b>Obstetricians</b>	6
<b>Grade</b>	
Consultant	4
Specialist Trainee Obstetrician or below	2
<b>General practitioners</b>	3

Table 3: Approaches to giving women their record and completing health and maternal histories

	Region A	Region B
Giving women their record	<p>Women collected their record [within a pregnancy pack] from primary care receptionist or community midwife before booking appointment.</p> <p>Women carried record from booking appointment onwards.</p>	<p>Midwives introduced record to women at booking appointment.</p> <p>Midwives retained record after booking appointment.</p> <p>Women were given their record to carry from around 16-20 weeks onwards.</p>
Approach to completing health and maternal histories	<p>Women completed health and maternal histories at home, before booking appointment.</p> <p>Midwives reviewed these with women at booking appointment.</p>	<p>EITHER: Midwife completed health and maternal histories in discussion with women at booking appointment.</p> <p>OR (in some localities): Women completed health and maternal histories at the clinic, immediately prior to booking appointment. Midwives reviewed these with women at booking appointment.</p>