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Research

Mothers' perceptions of primary health-care providers: thematic analysis of responses to open-ended survey questions

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Abstract. General practitioners and maternal, child and family health nurses have a central role in postpartum primary health care for women and their infants. Positive client-provider relationships are particularly important for women experiencing mental health problems or unsettled infant behaviour. However, little is known about their experiences of postnatal primary health care. The study aimed to describe views of postnatal primary health care among women completing a residential early parenting programme and to identify potential strategies to enhance provider-patient interactions. Participants ($n = 138$) were women admitted with their infants to a private or a public early parenting service in Melbourne, Australia. Women completed a detailed self-report survey, including open-ended questions about experiences of primary health-care services, and a structured psychiatric interview to diagnose anxiety and depression. Survey responses were analysed thematically. Womens' experiences of primary health care were influenced by their perceptions of provider competence and the quality of interactions. While similar positive characteristics of doctor and nurse care were valued, medical and nursing practices were judged in different ways. Women described GPs who listened, understood and were thorough as providing good care, and maternal, child and family health nurses were valued for providing support, advice and encouragement. Threats to therapeutic relationships with doctors included feeling rushed during consultations, believing that GPs were not mental health-care providers and the clinician not being 'good' with the infant; with nurses, problems included feeling judged or given advice that was inconsistent or lacked an evidence-base. Postpartum primary health care will be improved by unhurried consultations, empathic recognition, encouragement, evidence-informed guidance and absence of criticism.

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Introduction

It is well recognised that the quality of a relationship between patient and clinician influences health outcomes (Beach *et al*. 2006; Epstein and Street 2011). While there has been much research into the patient, clinician and interaction factors that shape these relationships, and in turn satisfaction with care, there has been relatively little qualitative exploration of patients' perceptions of care (Hudon *et al*. 2011). Positive perceptions of care may be associated with increased patient comfort and disclosure, uptake of referrals, compliance with treatment recommendations and behaviour change, and thereby patient outcomes (Kerse *et al*. 2004; McNaughton 2005; Potiriadis *et al*. 2008). However, negative perceptions of care may lead patients to ignore advice, avoid future consultations or delay seeking help, all of which are likely to increase the risk of poor health outcomes.

Women and postnatal primary care

In Australia, primary care is available for women with young children through general practitioners (GPs) and community-based maternal, child and family health nurses[1] (MCFHNs). GPs practice in bulk billing (care provided without cost to users because practitioners accept payment of the fee determined by the Australian Government under the *Medicare* universal health-care programme) or private billing services (Medicare rebate plus a charge to users). Women who have recently given birth are connected with a MCFHN that is from their local government area (Department of Human Services 2005). Regular appointments for the monitoring of infant health and development and vaccinations provide opportunities for mothers to seek both personal and infant care (Mbwili-Muleya *et al*. 2000; Goldfeld *et al*. 2003). These visits foster the development of patient–practitioner relationships and most women with infants access them regularly (Hughes *et al*.

[1]Terms vary to describe registered nurses who provide infant, child and family primary care. These include combinations of child, family and youth care nurse and public health nurse (Eronen *et al*. 2010). In this paper, a broad term 'maternal, child and family health nurse' will be used.

What is known about the topic?

- Women who have recently given birth have increased health care needs. Positive collaborative relationships with primary health-care practitioners are particularly important to ensuring good health outcomes.

What does this paper add?

- Primary medical and nursing practitioners who are experienced by mothers as empathic, unhurried, encouraging, evidence-informed and affirming are perceived as helpful and their care as valuable.

2011). While these professional groups have guidelines about delivery of evidence-informed postnatal care (The RACGP 'Red Book' Taskforce 2009; Department of Education and Early Childhood Development 2011), roles, styles of practise and caregiving differ between and within groups (Gunn *et al*. 1998). MCFHNs provide a fee-free service funded by combinations of state, territory or local governments, depending on the jurisdiction. Both GPs and MCFHNs have a vital role in supporting maternal and infant well-being (Woolhouse *et al*. 2009; Eronen *et al*. 2010, 2011); however, the way women experience this care and the practitioner traits they value or dislike are largely unknown.

Factors influencing patient perceptions of GP care

While patient satisfaction with care is often examined in general practice through survey research (Hudon *et al*. 2011), less attention has been paid to patients' views of what constitutes good care. There is some evidence that continuity of care and familiarity with the GP were most important to patients when consulting about more serious psychological or family problems (Kearley *et al*. 2001). However, regardless of the reason for consultation, familiarity with the GP also contributed significantly to positive ratings of GP care in terms of satisfaction, feeling helped and their perceived trustworthiness (Schers *et al*. 2005). GPs whose care was positively evaluated were valued for listening, providing confidentiality, making patients feel comfortable and ensuring that consultations were unhurried and of sufficient duration (Jung *et al*. 2002).

Factors influencing patient perceptions of MCFHN care

There has been little investigation of maternal perceptions of MCFHN care, although it appears that support, access, quality information and empowerment are important elements (Eronen *et al*. 2010, 2011). The available literature has investigated complexities in the relationship such as power imbalances and conflicting role expectations between mothers and MCFHNs. A New Zealand study of five Plunkett nurses (similar to MCFHNs), revealed that the nurses were focussed on developing and maintaining good relationships with the mothers while undertaking surveillance of infant development and social risks (Wilson 2001). However, Wilson (2001) proposed that a partnership between mother and nurse, a well-promoted ideal, may mask true power differences that arise when there is an 'expert' and an 'apprentice'. Evidence for the presence of power differentials came from reports of mothers withholding the truth, lying or using other forms of resistance against the MCFHN. A Swedish study that involved interviewing child health nurses and first time mothers found that the mothers had broad expectations of the nurses (Fägerskiold and Ek 2003). These included expecting nurses to act as counsellors, sources of knowledge, supporters, expert assessors of child development, immunisers and parent group organisers. However, the child nurses reported being child focussed and only occasionally providing support during parental/family problems. It is plausible that these more complex interactions and mismatched expectations, often unspoken, might influence womens' perceptions of care provided by MCFHNs.

Becoming a mother demands major adaptations for all women and some experience significant early parenting difficulties (Fisher *et al*. 2002; Woolhouse *et al*. 2009). Women have increased needs for high-quality, life-stage-specific advice following childbirth and a positive perception of health care may be especially important at this life phase. It is possible that they are more sensitive to unsatisfactory interactions with health-care providers regarding their own health and wellbeing and that of their infant. Australia's unique residential early parenting programmes provide specialised structured support to assist women with mild-to-moderate mental health problems who are caring for unsettled infants. Women admitted to these services have been found to be particularly vulnerable with significant emotional, psychological and physical health problems and are often experiencing coincidental adverse life events (Fisher *et al*. 2002). Many require increased primary health care after completing the early parenting programme, but uptake of these services among them can be uneven (Tweddle Child and Family Health Service, pers. comm.). The aim of this study was to investigate the perceptions of care provided by GPs and MCFHN among women attending residential early parenting programmes.

Methods

The present study used a cross-sectional, structured survey that included both items with fixed response options and open-ended questions. This paper reports on the analysis of the qualitative, open-ended responses concerning maternal perceptions of GP and MCFHN care. The methods of the broader study are described in detail elsewhere (Rowe *et al*. 2008).

Settings

The study was undertaken at two study sites in Melbourne, Victoria. The first, Masada Private Hospital Mother Baby Unit (MPHMBU), is a five-bed residential early parenting service, which admits women who have private health insurance with infants aged up to 12 months. The second site, Tweddle Child and Family Health Service (TCFHS), is a public-access service, which has 10 beds and admits mothers with children aged up to 48 months. These centres provide structured psycho-educational programmes that aim to treat early parenting difficulties by improving maternal knowledge and caregiving skills and reducing unsettled infant behaviours. Women require formal

referral from a medical practitioner in order to be admitted to MPHMBU, but can self-refer to TCFHS.

Participants

The inclusion criteria for participants were women admitted consecutively to either MPHMBU or TCFHS during the six-month recruitment period, with a child under 12 months of age, sufficient English to complete the questionnaire and interview, and capacity to provide voluntary and informed consent.

Data sources

A self-report questionnaire was used to assess general health, reproductive health, and social (relationship quality), psychological, and socio-demographic characteristics known to be associated with postpartum mental health. It included both study-specific items and standardised instruments. Data items and instruments described here are limited to those that yielded data reported in this paper. Experiences and perceptions of primary health care were assessed in both fixed-choice and open-ended questions. Participants were asked if 'you currently consult a family doctor or MCFHN regarding your own health and/or your baby's health?' (yes/no), to describe 'your perception of the care provided by this person (GP and MCFHN) in your own words' (open-ended), and, if they did not have a link to at least one of these primary health-care providers, to describe 'what has prevented you consulting a (family doctor or MCFHN) about your own health?' (open-ended).

Diagnoses of anxiety and depressive disorders were ascertained using the Composite International Diagnostic Interview (CIDI), a structured clinical interview. Interviews were conducted by trained interviewers to ascertain psychiatric diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Andrews and Peters 2003). The anxiety, depression and socio-demographic modules of the 12-month version of CIDI-auto were administered. Questions prefaced with 'within the last 12 months' were reworded to 'since the birth of your baby'.

Procedure

On the first day of admission to either service, a pack of study materials containing information about the study, a consent form and the questionnaire was given to each eligible woman. All women were asked to return the materials, whether completed or not, in a sealed envelope to an accessible locked box in the ward, during the admission. Consenting women were also interviewed using the CIDI in their individual rooms or an alternative, private space.

Data management and analysis

CIDI diagnoses and participant responses to fixed-choice survey items were entered into an SPSS database and analysed using descriptive statistics. Text responses to open-ended questions about primary health care were transcribed and analysed thematically. Text responses were read repeatedly for immersion in the data and were independently examined by the authors. Themes were identified, coded and categorised based on overarching *a priori* themes that shaped the open-ended questions, as well as on new, emerging themes (Green *et al.* 2007).

Ethics

Ethics approval was obtained from the Human Research Ethics Committees at the University of Melbourne Human Research Ethics Committee and the Avenue Hospital, and from the Board of Tweddle Child and Family Health Service.

Results

In total, 138 eligible women (75% response rate) completed the questionnaire. The mean age of respondents was 33 years (s.d. 4.3). The majority had completed post-secondary school education (81%), were born in Australia (84%) and were married (105; 81%). Many women reported a physical health problem (85%), most commonly back ache (64%), headaches or migraines (39%) and haemorrhoids (18%). Approximately two-thirds (63%) met CIDI diagnostic criteria for Major or Minor Depression, Generalised Anxiety Disorder or Specific Phobias. Eighty-three per cent of women had a regular family doctor (GP) and 95 per cent had a MCFHN.

Text responses to open-ended questions about access to, and use of primary health-care services ranged from one word to several sentences, grouped into the following themes. A high proportion of women (95%) provided responses to the two fixed and four open-ended questions included in the analysis.

Not having a regular family doctor or maternal, child and family health nurse

Reasons for not having a regular family doctor varied from the practical to the personal. The most common responses were that the woman had 'no health concerns' (Mother aged 30, infant 34 weeks) and specifically, no concerns with physical health: '[I] don't believe I have any physical problems, just stress of having a new born' (Mother aged 33, infant 19 weeks). Another sub-group of women felt that they did not have enough time to have a regular doctor. It is unknown whether they consult doctors in a group practice or if they generally miss out on medical care due to being time poor. Two other practical reasons for not having a regular doctor were that the woman attended a clinic where they had no personal or ongoing relationship with a particular doctor, but rather saw who was available when they attended, or that they had recently re-located away from their regular GP and were yet to find one in the local area.

Many participants referred to the importance of finding a GP whom they liked. The absence of a good fit between themselves and GPs they had consulted prevented them from having a regular GP. '[It's] difficult to find a doctor I feel comfortable with and feel is competent and helpful' (Mother aged 36, infant 9 weeks). Last, for one participant, being prescribed unwanted medication triggered a negative perception of clinician competence '[I was] given unnecessary medications' (Mother aged 34, infant 16 weeks). As a result she had not established a relationship with a regular GP.

It was rare for participants not to have a MCFHN. One mother made clear her view of a MCFHN role in her comment 'I'm not due for a visit for quite some time and feel there is nothing worrying me enough about my baby's health and development' (Mother aged 34, infant 43 weeks). Another had stopped attending a MCFHN as she 'Got bad advice in the beginning' (Mother aged 42, infant 35 weeks). Satisfaction with GP care

and having relocated to Australia after being in a country with no MCFHNs were other reasons outlined.

Enabling aspects of GP health care

Of all the GP attributes, sensitive care was valued most highly. It was described frequently as a key characteristic of GPs whose patients reported positive perceptions of care '[My GP is] a thoughtful, concerned GP who if anything cares too much for his patients' wellbeing and as a consequence is very popular.' (Mother aged 40, infant 37 weeks).

Many participants indicated that a GP who makes patients feel understood provides good care. Descriptions such as supportive, reassuring, compassionate and most commonly, understanding, illustrate how empathic and supportive interactions created positive perceptions of care. This support appeared to contribute to a trusting relationship and increase likelihood of taking up necessary referrals, such as to early parenting centres: 'Our GP is great. She has been very supportive and she was the one to refer me to Tweddle' (Mother aged 36, infant 32 weeks). A crucial part of empathy involves listening, and doctors described as understanding were often also described as being good listeners: 'He is an excellent doctor, very understanding. He listens well' (Mother aged 29, infant 22 weeks).

The theme of 'my GP makes time for me' appeared to be central to women feeling valued and supported. Many participants referred to instances when their GP had fitted them in for an appointment 'I find our doctor wonderful, helpful and will always see us even when fully booked out' (Mother aged 36, infant 32 weeks), telephoned them to follow up their concerns, or went '...beyond the call' (Mother aged 32, infant 10 weeks) to meet their needs. In a related theme, women described personalised care and attention as highly valuable, for example, knowing family members' backgrounds and expressing genuine interest in both mother and baby. Lastly, specific personality traits of GPs were also said to contribute to the perception of care. These traits included being easy going, gentle, considerate and genuine. Being open-minded or non-judgemental was also highlighted: 'A very easy to talk to doctor, broad-minded and helpful' (Mother aged 33, infant 32 weeks).

Barriers to GP health care

The perception that GPs only treat physical illness meant that some mothers rarely attended a GP or attended only when needing medication. Capturing this view was the comment '[I] only visit when physically unwell, often only for medication or repeat prescription, maybe 1–2 times a year' (Mother aged 32, infant 38 weeks). Another woman wrote that she saw her GP for 'General consultations for referrals or when a problem arises (cure rather than prevention)' (Mother aged 35, infant 30 weeks). Furthermore, several women reported that they have no need to see a GP, despite being admitted to a residential early parenting centre for maternal fatigue and unsettled child behaviour: 'Never needed to' (Mother aged 28, infant 12 weeks).

Among problems described by participants, length of consultation, waiting to be seen and difficulties getting an appointment were the most common. Many doctors were described as being too busy, resulting in consultations that felt rushed, and left some participants wondering about the quality of practice, for example, 'Quite good doctor but very busy so not convinced her answers are considered' (Mother aged 32, infant 19 weeks). Some participants found problems with trying to get an appointment to see their GP and lengthy waits before being seen. In particular, one wrote 'Once I get in to see them, my doctor is very good, professional and courteous but they are often running very late of [sic] appointment times' (Mother aged 31, infant 26 weeks).

Difference of opinion was a problem for women who found they did not agree with their GP about treatment options and next steps. This may have played out through GPs discounting mothers' preferences for following up concerns or health problems, for example, '...our doctor does not share our beliefs that specialist practitioners are needed in some cases' (Mother aged 27, infant 49 weeks) and '[My GP is] patronising and close-minded to alternatives' (Mother aged 36, infant 38 weeks). One participant disagreed with her GP's approach to health care: 'I feel that she just wants to fix the symptoms with medication but not the underlying issue' (Mother aged 27, infant 28 weeks).

Enablers to MCFHN care

The primary elements highlighted by mothers as integral to good quality care from a MCFHN were providing advice and information that were perceived to be appropriate and helpful. 'I find the health nurse flexible in trying different avenues to find the right solution to any problem my child may have' (Mother aged 35, infant 45 weeks). Other commonly described components of good care were being supportive and reassuring. Similar to GPs, caring MCFHNs were highly valued and this trait was frequently written about. As described by one mother 'I could not have asked for a more supportive person. She is both sensitive and caring as well as a wealth of practical and useful advice' (Mother aged 36, infant 9 weeks). Mothers also mentioned personality traits related to their perception of good nurse care including being friendly, genuine, honest and non-judgemental.

Barriers to MCFHN care

Tensions in the relationship between MCFHN and mothers stemmed from their feelings of being judged and disagreeing with the nurse's advice or opinions. Some mothers felt their nurses were being too opinionated, which contributed to their anxiety and distress. Examples of this included '...They're usually old school. Often make me feel bad about my baby's size' (Mother aged 33, infant 40 weeks) and '... [she] made me unnecessarily anxious regarding failure of baby to gain weight when 4 months old' (Mother aged 34, infant 46 weeks). Two mothers believed their MCFHNs over-reacted to situations concerning their children and themselves. One wrote 'Tends to unnecessarily panic at times. Appears to defer to doctor's second opinion a lot' (Mother aged 35, infant 39 weeks). Another mother described with passion her opinions of care from her MCFHN 'Completely pathetic. Worse than pathetic. Alarmist, judgemental, inclined to silly pronouncements' (Mother aged 40, infant 37 weeks).

Although most mothers indicated that it was the role of a MCFHN to provide advice, this was a contentious issue due to its ability to cause mothers stress and distress. Some mothers who reported dissatisfaction with care wrote that their MCFHN

gave advice that was 'old school', 'out of touch', 'by the book' and 'black and white'. Poor advice was the most common reason provided for MCFHN care perceived as poor 'I have no confidence in her abilities and knowledge. She gives poor advice.' (Mother aged 32, infant 24 weeks). Inconsistent advice was also problematic when mothers were visiting a centre in which there were several MCFHNs or other health professionals: 'I find different MCFHNs give conflicting or confusing information. There seems to be a lot of inconsistency in information i.e. baby settling and routines, feeding' (Mother aged 33, infant 32 weeks).

Incidents of missed diagnoses or incorrect diagnoses made by their MCFHN were mentioned, which detracted from care mothers found otherwise satisfactory. For example, one mother wrote 'I was wrongly diagnosed with postpartum psychosis by the MCFHN when in fact I was not even depressed. She came to this conclusion after a few questions rather than using depression scales/questionnaires' (Mother aged 27, infant 49 weeks). Another mother felt that the MCFHN failed to assist with the diagnosis and treatment of her infant's reflux problem.

Seeing multiple nurses or 'losing' their preferred nurse due to rotations was also described: 'Our council in its wisdom decided to rotate all nurses to different centres so we have lost our nurse (who was excellent and our built up relationship)' (Mother aged 36, infant 36 weeks). Poor-to-moderate quality of care was reported by several women who felt that their MCFHN avoided making further appointments with them or did not allow an opportunity for them to discuss issues important to them,.'... seems not interested and tends to fob me off if I ask for an appointment to discuss problems' (Mother aged 39, infant 24 weeks). Many women told of the limited staffing in MCFHN services compared with the community demand such as 'Haven't connected. She is always too rushed and busy. I feel I can't take time and talk to her' (Mother aged 36, infant 36 weeks). Others described care as minimal, superficial and almost entirely child focussed: '[My MCFHN] measures and records baby development and stats i.e. weight. Assesses development at specific ages. Listens to mother, but mainly focussed on baby (Mother aged 32, infant 38 weeks).

Discussion

Qualitative data from this large, systematically recruited sample with a high response rate highlights the centrality of the emotional climate as well as the technical ability of how new mothers admitted to residential early parenting centres perceive primary care. Data were analysed from written responses to open-ended survey questions and, given that participants took the opportunity to provide elaborated responses as part of an in-depth survey as well as during their admission to a residential early parenting service, which is a personally challenging time, suggests they were salient. Positive maternal perception of care was the product of appropriate emotional support from practitioners such as them being caring and understanding, as well as technical expertise and appointments that are accessible (e.g. appointment availability) and adequate in length. Negative perceptions of care were the result of feeling judged or rushed, being given poor advice, having anxiety aroused and from being excluded from decision-making. This study contributes evidence from new mothers to two key questions posed by Stewart (2004) concerning quality of care and patient–clinician relationships: 'What aspects [of the therapeutic relationship] do patients expect and value?' and 'What can clinicians do or not do that will support the development of a positive and therapeutic relationship?'.

Women without a family doctor

For women either with or without a regular family doctor, there was often a perception that the role of the GP is to support physical wellbeing, rather than to address problems with mental health or parenting. These responses may be due to some participants perceiving a separation between psychological and physical wellbeing, or that GPs do not have a role in their mental health care. Women have reported discomfort with discussing psychosocial problems in the antenatal period with both GPs and midwives (Hegarty *et al.* 2007). Outside of the perinatal period, the view that GPs should not be asking about, and therefore seeking to address, psychosocial issues was shared by a significant number of GPs in an Australian study (Gunn *et al.* 1998). This perception may be carried through to interactions with mothers following childbirth and making them less conducive to enquiry and patient disclosure. The belief expressed by some mothers and GPs that GPs only treat physical health problems (Gunn *et al.* 1998) is concerning given the extent of poor mental health and comorbidity in this population of women (Fisher *et al.* 2002; Rowe *et al.* 2008). By asking questions concerning psychological and social wellbeing, GPs may open the consultation to important issues related to mental health that exist or may arise in the future (Rowe *et al.* 2008); however, this questioning must be supported by appropriate education and training to increase practitioner skill and confidence (Chew-Graham *et al.* 2009). This approach is part of proactive, rather than reactive, postnatal care that includes enquiry about a range of physical, emotional and parenting issues (Piejko 2006).

Positive perceptions of GP and MCFHN care

Women can articulate the qualities that make up good quality primary care easily and succinctly. These findings speak to the art of medicine rather than the science, as they involve the interpersonal and emotional aspects of caregiving. It is encouraging that there are so many positive experiences and care perspectives reported concerning GP and MCFHN providers, particularly for a group of mothers who often have complex and ongoing medical and parenting needs. Overall, findings point to the need for GPs and MCFHNs to be reassuring, non-judgemental and understanding in encounters with new mothers, to provide high-quality evidence-informed advice and to encourage women in their new roles and responsibilities.

Negative perceptions of GP care

Perceptions of care were often negatively influenced by characteristics of a general practice system that is not always able to meet the needs of patients. This appeared in comments of feeling rushed through appointments or unable to make necessary appointments due to a lack of GP availability. This

problem is well documented. There has been concern for some time that the quality of relationships may be under threat due to large demands on the Australian general practice system (Lings *et al*. 2003). Although appointment availability may not be amenable to change, booking double appointments for new mothers would create more time for new mothers and support the development of stronger relationships between practitioner and patient.

When describing their perception of care, a group of women in this study highlighted that their perspectives were simplified, overlooked or ignored. Models of patient–physician care have been discussed in medicine for several decades and a prominent theory, the Four Models of Physician-Patient Relationships, points to ways to improve this potentially disempowering and frustrating scenario (Emanuel and Emanuel 1992). Central to the model is advocacy to move from paternalistic clinical decision-making to deliberative decision-making, where care decisions are shared between physician and patient and involves the physician teaching rather than telling (Emanuel and Emanuel 1992). In recent times, it has been asserted that asking the patient how they would like to be involved in decision-making will lead to more tailored and satisfactory outcomes for the patient (Clarke *et al*. 2004). By GPs asking mothers how they would like to make decisions about their own health and their child's wellbeing and being open to their perspectives, perceptions of care may be significantly improved.

Negative perceptions of MCFHN care

Unlike GP relationships, which may be longstanding, a new relationship begins with a MCFHN after first, and sometimes subsequent childbirth, and there has not been time to develop trust or for MHCNs to demonstrate expertise. Although technical aspects where largely overlooked when describing GP care, there was some criticism of the consistency and currency of advice given by MCFHNs. Empowering mothers in decision-making and consistency of advice are key priorities for new parents (Eronen *et al*. 2010, 2011). Currently, MCFHN training is not standard across institutions and has been described as inadequate preparation for the complex MCFHN role (Kruske and Grant 2012). As approaches to parenting can vary widely and there are multiple avenues to find information (Halfon *et al*. 2002), it is important to ensure that advice is consistent and evidence-informed across providers and centres. Of concern was the anxiety aroused by interactions with some MCFHNs that naturally led to negative perceptions of MCFHN care. Anxiety may have been aroused by MCFHNs appearing alarmed about child development or appearing to judge mothers. In contrast, contemporary nursing practice and theory highlights shared problem identification and problem solving (McNaughton 2005). To avoid the apprentice–master relationship (Wilson 2001) that is still commonplace despite a policy shift towards partnership (Kruske *et al*. 2006), MCFHNs should be given ongoing opportunities for professional development to refine skills in partnering with women to problem solve and work through concerns with mothers in a calm, non-judgement and encouraging way. In addition, problems of role conflict were highlighted where the MCFHN was child focussed to the exclusion of maternal health and wellbeing concerns. This is consistent with international evidence, which found mothers expected nurses to serve a variety of roles including maternal care whereas nurses highlighted child-focussed tasks (Fägerskiold and Ek 2003). Working with mothers and MCFHNs to find common ground in terms of role expectation early in consultations may serve to avoid these problems in future.

The MCFHN system is under-resourced (Kruske *et al*. 2006) and subject to a share of limited public health funding (Rowe and Barnes 2006). This situation may underlie mothers being discouraged from taking up subsequent 'follow up' visits and having short or rushed consultations. This is a concern, given the need for quality primary care for all women, especially those experiencing high physical, emotional and parenting needs (McNaughton 2005). In this instance, advocacy for increased funding to the MCFHN system is likely to be necessary. Of great concern is how the capacity of practitioners to interact optimally with mothers may be constrained by the poor psychosocial support and working conditions that practitioners may experience due to underfunded roles in which there are multiple competing demands.

Although situated in Australia and sampling only mothers attending early parenting centres, the results of this study support those from another study of mothers with young infants attending Australian MCFHN services and another in general practice patients in an ethnically diverse USA sample. Consistent with this study, mothers highly valued empowerment and respectful interactions, good-quality advice from MCFHNs and accessible services (Eronen *et al*. 2010). Participants in the US study reported similar positive attributes in clinicians, which were divided into good communication (listening, reassurance), 'personal impact' (including care, understanding and liking) and professionalism (medical competence and personal integrity) (Lings *et al*. 2003). This indicates that new mothers experiencing problems with high morbidity from physical and emotional problems are nonetheless broadly comparable with other patient populations concerning care perceptions.

Limitations

This study provides a thematic analysis of perceptions of primary care quality from a sample of women with high needs attending residential early parenting services. Findings are derived from open-ended survey questions and are limited to the responses provided by participants following an extensive questionnaire during admission. Although response rates to the survey were high, the findings are most relevant to mothers attending these services and should be extended to other mothers of young children with caution.

Conclusions

These findings present clear opportunities for clinicians to enhance their current work practices by reflecting on the attributes and encounters that are perceived to have an impact on care quality, and ensuring that primary care providers have the necessary evidence-based training and support to respond to maternal needs. This paper calls for a continued focus on supportive interactions with new mothers to ensure that they

seek and take up the services needed for them and their family in the postnatal period and beyond. It also points to a need for greater maternal understanding and support to use GP services for mental health needs.

Conflicts of interest

None declared.

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