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Opinions of professionals about integrating midwife- and obstetrician-led care in The Netherlands

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A B S T R A C T

Objective: the current division between midwife-led and obstetrician-led care creates fragmentation in maternity care in the Netherlands. This study aims to gain insight into the level of consensus among maternity care professionals about facilitators and barriers related to integration of midwife-led and obstetrician-led care. Integration could result in more personal continuity of care for women who are referred during labour. This may lead to better birth experiences, fewer interventions and better outcomes for both mother and infant.
Design: a descriptive study using a questionnaire survey of 300 primary care midwives, 100 clinical midwives and 942 obstetricians.
Setting: the Netherlands in 2013.
Participants: 131 (response 44%) primary care midwives, 51 (response 51%) clinical midwives and 242 (response 25%) obstetricians completed the questionnaire.
Findings: there was consensus about the clinical midwife caring for labouring women at moderate risk of complications. Although primary care midwives themselves were willing to expand their tasks there was no consensus among respondents on the tasks and responsibilities of the primary care midwife. Professionals agreed on the importance of good collaboration between professionals who should work together as a team. Respondents also agreed that there are conflicting interests related to the payment structure, which are a potential barrier for integrating maternity care.
Key conclusions: this study shows that professionals are positive regarding an integrated maternity care system but primary care midwives, clinical midwives and obstetricians have different opinions about the specifications and implementation of this system.
Implication for practice: our findings are in accordance with earlier research, showing that it is too early to design a blueprint for an integrated maternity care model in the Netherlands. To bring about change in the maternity care system, an implementation strategy should be chosen that accounts for differences in interests and opinions between professionals.

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Introduction

A division between midwife-led and obstetrician-led care traditionally characterizes maternity care in the Netherlands, but pregnant women, professionals and other stakeholders are increasingly questioning this division. One of the consequences of this division is that after transfer from midwife-led care to obstetrician-led care, the primary care midwife is no longer involved which results in discontinuity of caregiver (Wiegers, 2009; de Jonge et al., 2014) potentially leading to loss of important obstetric information (Evers et al., 2010) with a potential impact on quality and safety of care. In this study, “integration of care” is defined as closer collaboration between midwives and obstetricians. Integration of midwife-led and obstetrician-led care by shifting existing tasks and responsibilities during labour could enhance personal continuity of care for women, possibly leading to fewer instrumental deliveries, less need for pain relief (Sandall et al., 2015) and more satisfaction among women (Rijnders et al., 2008).

The principal caregivers for women with low-risk pregnancies in the Netherlands are self-employed primary care midwives who work in private practices in, so-called midwife-led care. Women in primary care at onset of labour can choose to give birth either at home or in a hospital under supervision of their primary care midwife. If a primary care midwife identifies a risk factor during pregnancy or labour, she will refer a woman to an obstetrician who takes over responsibility for her care: so-called obstetrician led care. In total, 85% of women start their pregnancy in midwife-led care and eventually 29% of all pregnant women give birth in midwife-led care (Stichting Perinatale Registratie Nederland, 2013a). Indications for referral to or consultation with an obstetrician during pregnancy and labour are listed in the national guideline “The List of Obstetric Indications” (Diemen: College voor Zorgverzekeringen, 2003). Women can be referred back to primary care when appropriate. However, about 50% of pregnant women starting in midwife-led care are referred at some stage during pregnancy and start labour in secondary care. The number of referrals during labour has increased steadily during the past years from 15% in 2010 (Stichting Perinatale Registratie Nederland, 2010) up to 23% in 2013 (Stichting Perinatale Registratie Nederland, 2013b). This rise is mainly a result of more referrals for non-urgent reasons (Offerhaus et al., 2013), such as meconium stained liquor, the need for pain medication or failure to progress during the first stage of labour (Stichting Perinatale Registratie Nederland, 2013b).

The List of Obstetric Indications only distinguishes “high-risk” and “low-risk” indications. A “moderate risk” indication does not formally exist at present. In this study we defined referral indications with a high probability of good maternal and neonatal outcome (Perdok et al., 2015), such as the need for epidural anaesthesia for pain relief and meconium stained amniotic liquor, as “moderate risk”. All women who develop “moderate risk” indications during labour are currently classified as “high risk”, and referral takes place to an obstetrician, which means that care is handed over (Diemen: College voor Zorgverzekeringen, 2003). In daily practice the obstetrician often delegates the care to a clinical midwife (Cronie et al., 2012).

The primary entry to practice qualification for midwifery in the Netherlands is a four year Midwifery degree, at higher professional education”. On graduation midwives can choose to work as a primary care midwife providing full scope of practice care for women experiencing an uncomplicated pregnancy. Alternatively, midwives can choose to work within the hospital system as a clinical midwife under the responsibility of the obstetrician. Clinical midwives provide midwifery care for women, referred to obstetrician led care, who experience complications or have developed risk factors that require secondary care. Clinical midwives are experienced in additional tasks such as conducting continuous electronic fetal heart rate monitoring (EFM) and augmentation of labour. Clinical midwives deal with complicated pregnancy and birth, built on a foundational knowledge base through experience and work under the responsibility of an obstetrician. A postgraduate education to enable them to take on these "additional " tasks exists in the Netherlands and is expected to become obligatory in the near future. Of all births in obstetrician-led care 40% are managed solely by a clinical midwife (Cronie et al., 2012). Obstetricians will only be actively involved if additional risks or problems occur, such as fetal distress or the need to perform an operative childbirth. Obstetric nurses assist the midwife or doctor during labour in hospitals.

Countries such as New Zealand (Lee and Walker, 2011) and Canada (Canadian Association of Midwives, 2010) have a well-integrated primary and secondary care structure. Midwives move between primary and secondary care settings and continue to care for women transferred to secondary care, leading to more personal continuity of care for women. In these two countries, midwives are trained and have the skills required to care for women who are transferred.

We hypothesise that if women with “moderate-risk” indications continue to receive care from their primary care midwife during labour, this will lead to more personal continuity of care, (Uijen et al., 2012) which is likely to increase women's birth satisfaction (Rijnders et al., 2008) and contribute to their feeling of safety during labour (de Jonge et al., 2014). In addition, this may lead to health benefits such as a reduction of medical interventions with a similar or lower rate of maternal and neonatal morbidity (Hodnett et al., 2007). If the primary care midwife were to provide care to women with a “moderate risk” indication this would require a major change in the organisation of Dutch maternity care and would need more collaboration between primary and secondary care with joint care pathways and additional tasks for the primary care midwife, such as the use of continuous EFM.

Changes in tasks and responsibilities require consensus among all maternity care professionals involved. In the “INtegrated CAre System”(INCAS) study, the barriers and facilitators for integration of care during labour in the Netherlands were examined. In a Delphi-study with a panel of 50 professionals, we found a lack of consensus with regard to redistribution of responsibilities and tasks among Dutch maternity care professionals including primary care midwives, clinical midwives and obstetricians, and a wide variety of opinions about the ideal organisation of care (Perdok et al., 2014).

In the study reported here we followed up the previous Delphi study (Perdok et al., 2014) in order to investigate (a) the level of consensus among maternity care professionals regarding facilitators and barriers to integrate midwife-led and obstetrician-led care for women at “moderate risk” and (b) the level of consensus among maternity care professionals regarding tasks and responsibilities of professionals when caring for women with “moderate risk” factors.

Methods

Study design

To obtain the opinions of maternity care professionals we developed an online questionnaire and in February/March 2013 invited midwives and obstetricians to complete this by sending them a link (Survey Monkey, Palo, Alto, CA, USA) via e-mail. Nonresponders received a reminder by e-mail after two weeks.

In the Netherlands a total number of 2852 midwives (Netherlands Institute for Health Services Research (NIVEL), 2014) and 942 obstetricians were active in maternity care, as of January 1, 2013.

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