



Exploring Dutch midwives' attitudes to promoting physiological childbirth: A qualitative study



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ABSTRACT

Objective: to describe Dutch midwives' attitudes toward, and motivations for, the promotion of physiological childbirth and to identify factors associated with those attitudes and motivations.

Design: exploratory, qualitative design using focus groups.

Setting: The Netherlands.

Participants: hospital- and community-based midwives.

Findings: four themes emerged: physiological birth as a continuum, navigating the settings, woman-centeredness and competence and confidence.

Midwives view the safeguarding and promotion of physiological childbirth as central to their role. They define physiological childbirth along a continuum that is related to the context of their practice. Hospital culture is seen as an inhibitor of practices that promote physiological birth.

Midwives believe that woman-centred ways of working and challenging practices that are not evidence-based will promote physiological childbirth.

Key conclusions: in order to become competent and confident practitioners of physiological childbirth midwives need to be aware of the factors that inhibit and encourage practices that support this way of giving birth.

Implications for practice: midwives should consciously employ strategies that promote physiological birth in both home and hospital settings. Midwifery education and midwifery science research should focus on developing strategies that support midwives in this endeavor.

Introduction

In high income countries, one of the great public health achievements of the 20th century was the dramatic improvements in the health of pregnant women and their babies. Developments included the availability of antibiotics, greater access to health care and technological advances in perinatal medicine, all of which contributed to safer births (CDC, 2013). In Europe, in particular, improvements were as a consequence of the development and accessibility of midwifery techniques (De Brouwere et al., 1998) together with active national strategies for the training of midwives (De Brouwere and van Lerberghe, 2001).

Medicalization of childbirth is a phenomenon in all high income countries (Christiaens et al., 2013) despite, evidence demonstrating that routine intervention in the birthing process creates iatrogenic harm to women and babies (Requejo et al., 2012) and adds substantial economic costs to health care systems (McIntyre et al., 2011).

More recently both women and midwives criticized the medicalization of childbirth, rejecting unnecessary interventions (MCWP, 2007; ACNM, 2012) and encouraging a view of birth as a physiological, life event. Contemporary evidence supports the physiological approach to birth as an optimal means to improve the health of women and their babies (Renfrew et al., 2014). Moreover, midwifery-led models of care are associated with both fewer medical interventions and increased

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satisfaction with the birthing experience (Sandall et al., 2015).

In most industrialized countries, the pervasive obstetric argument for the safety and efficacy of hospital birth was coupled with the devaluation of domiciliary midwifery services (Cahill, 2001). The Netherlands, on the other hand, maintained a system in which community-based midwifery played a dominant and essential role (De Vries, 2005) and where home birth remains an accepted and well-integrated part of the maternity care system (Christiaens et al., 2013). Maternity care in the Netherlands is based on the principle that pregnancy and childbirth are fundamentally physiological processes. Independent midwives provide care to healthy women with uncomplicated pregnancies, referred to as midwife-led care. Midwives refer women to obstetrician-led care when there are complications or an increased risk of complications, as defined by the List of Obstetric Indications, a national guideline developed cooperatively by all the professions involved in maternity care (Obstetric Vademecum, 2003).

Whilst there is increasing consensus on the effectiveness of midwifery care (Renfrew et al., 2014; Ten Hoope-Bender et al., 2014; Sandall et al., 2015) and the strengthening of midwifery internationally (Ten Hoope-Bender et al., 2014), the Dutch system of midwifery care is changing. There has been a shift in the birth culture, with increasing numbers of women opting for hospital birth (CBS, 2011). This is possibly the result of concerns about seemingly high levels of perinatal mortality at home compared to the hospital (EuroPeristat, 2004); Following the publication of this report, subsequent media attention linked the seemingly high levels of perinatal mortality with the way in which midwifery care is organized (De Vries et al., 2013). Research has demonstrated a considerable rise in the rate of intrapartum referrals from midwifery to obstetrician-led care, without significant improvement in perinatal safety (Offerhaus et al., 2013). As a result of this transfer of care, women who begin labour in midwife-led primary care are experiencing increased use of obstetric interventions (Offerhaus et al., 2015a). Interestingly, there is a wide variation in the rate of referrals between midwifery practices, predominantly among non-urgent referrals during the intrapartum period, with rates varying between 9.7 and 63.7%. This variation cannot be explained by maternal characteristics alone: it is clear that factors relating to the way in which midwives practice play a significant role. Differences in management of the first stage of labour, the use of non-supine birthing positions or regional hospital policy may be influencing factors (Offerhaus et al., 2015b). Another factor is the perception of risk among midwives. Offerhaus et al. (2015c) found that midwives have a tendency to over-estimate the likelihood of risk and under-estimate the probability of a spontaneous vaginal birth.

The experience of physiological childbirth can be life changing for women (Humenick, 2006) and the midwife is a powerful facilitator for the provision of empowering, woman-centred care (Kennedy, 2002). Dutch midwives have a role to play in creating and strengthening opportunities for physiological childbirth, but they are not always aware of, or choose not to use, strategies that promote physiological birth outcomes (Offerhaus et al., 2015b).

In this study we explore Dutch midwives' attitudes and motives with regard to promoting physiological childbirth and identify the factors that encourage or inhibit this.

Methods

Design

We used focus groups to explore midwives' attitudes regarding promoting physiological childbirth, asking participants to reflect on the factors that encourage and inhibit practices that promote physiological birth. In order to focus our discussion, we asked participants about their use of non-supine birthing positions as an exemplar of a physiological approach to care.

Table 1
Characteristics of participants.

Demographic factor	Hospital-based midwives (H-B), n=14 Mean (range)	Community-based midwives (C-B), n=23
Age (years)	44.5 (27–62)	42.8 (26–59)
Qualification as midwife (years)	17.1 (4–38)	16.4 (4–38)
Work experience in present setting (years)	10.7 (3–28)	15.4 (4–33)
Midwifery education (country)	10 Dutch trained 4 Belgian trained	13 Dutch trained 2 Belgian trained 1 British trained

* No demographics recorded for 6 participants.

Setting and participants

We initially held focus group discussions with three groups of hospital-based midwives (H-B, n=14) in late 2013. On the basis of the findings from the first three focus groups, we subsequently decided to extend the research to include community midwives, thus reflecting both work settings of midwives in the Netherlands. Four focus groups were conducted with community-based midwives (C-B, n=23) in early 2015.

In the Dutch maternity care system, hospital-based midwives are salaried employees whilst community midwives are self-employed and work independently in small, group practices. The seven groups were homogenous in terms of their work setting but were mixed in terms of age, work experience and educational background (see Table 1). The focus groups ranged in size from three to nine participants, adequate to ensure discussion (Morgan, 1998). Written informed consent was obtained and ethical approval was granted (Atrium-Orbis-Zuyd number 13-N-34).

Data collection

We used the Attitude, Subjective Norms and (self) Efficacy (ASE) model (de Vries et al., 1988) to create a semi-structured focus group script. This model offers a framework for exploring how attitudes, norms and self-efficacy facilitate or inhibit new behaviour. The script was pilot-tested on a group of midwifery lecturers to confirm clarity and open-endedness of the questions. Using their feedback, we made minor edits to the script.

The focus groups lasted between 65 and 90 minutes. The discussions were audio-recorded and transcribed verbatim by the first author. Transcripts were checked against audio-recordings for accuracy. Participants were assigned a pseudonym in order to maintain anonymity.

Analysis

Data analysis was carried out concurrently with data collection, allowing the authors (ST, MN) to reflect upon the viewpoints of participants and learn from them. This led to small modifications of questions or the sequencing of questions in subsequent focus groups. When data collection was complete, we began thematic analysis, as described by Braun and Clarke (2006). Transcripts were read and re-read in order to become familiar with the data. Following this, the first author attached codes to small segments of the transcripts. Codes were then reviewed by the second author. Themes emerging from the data were identified and these were checked to determine relevance in relation to the data. This was done visually, utilizing thematic networks (Attride-Stirling, 2001). Candidate themes were refined and reviewed, going back to the data to establish coherent patterns (Braun and Clarke, 2006) and these were reviewed again by the second author.

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