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Midwives' perceptions of women's preferences related to midwifery care in Germany: A focus group study

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ABSTRACT

Objective: To explore how midwives perceive patient preferences related to midwifery care in Germany.
Design: This qualitative study, which was part of a larger study, used a hermeneutic-interpretive approach and involved focus group interviews with midwives. Data collection and analysis were done in a conjoined fashion between April 2015 and September 2016.
Setting: Four focus group interviews were conducted in four different federal states of Germany.
Participants: The sample of 20 qualified midwives was heterogeneous with regards to age, educational level, professional experience, type of midwifery care provided, and setting (employed, caseload, education) in which they provided services.
Findings: Three main themes were identified: Strengths and limitations of midwives' present professional profile (midwives' area of responsibility, range of services, and competency); lack of midwives and midwifery services; women's experiences of conflict in interprofessional care. Each main theme is broken down into several aspects of content.

Many women are not aware of the scope of professional knowledge and expertise of midwives. Moreover, the poor delineation of midwives' and obstetricians' areas of competency in Germany's hospitals seems to be disadvantageous for the women.

Midwives feel that due to context implications they cannot live up to the quality of midwifery care they aspire to. Lack of midwives results in midwives being overwhelmed, women underserved, and both disappointed.
Conclusions/implications for practice: On the one hand, new models of midwifery/maternity care need to be developed to solve some of the existing problems; on the other hand, new forms of interprofessional cooperation and management of transition of care points are required. Overall it is important that changes are implemented in such a way that women are enabled, and welcome, to clearly state their preferences for midwifery and maternity care. Particularly in Germany, tertiary education of midwives is needed to broaden their expertise and place them on an equal footing with obstetricians.

Introduction

Three practice categories are described for all childbearing women and infants within the framework for quality maternal and newborn care (Renfrew et al. 2014): (1) education, information, and health promotion; (2) assessment, screening, care planning; and (3) promotion of normal processes, prevention of complications. According to Renfrew et al. (2014), the practices within these categories are 'most effective when integrated into the health system in the context of effective teamwork, referral mechanisms, and sufficient resources'. For midwifery practice to be functionally embedded within the healthcare system, it needs to be 'available, accessible, acceptable' (organisation of care), respectful, understanding and woman-centred (values), to focus on promotion of physiological processes, strengthen resources and take a non-interventional stance (philosophy). Midwives and other health-care providers need to be interpersonally and culturally competent and maintain clarity of roles and responsibilities in interprofessional service provision (Renfrew et al., 2014).

Midwifery care in Germany

Until 2008 all midwives (after having completed general education

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at secondary school level) undertook 3 years of training at hospital-associated schools for non-academic health professions. After passing state examinations they received a diploma and were licensed as midwives in Germany. In 2008 a state law was passed permitting Bachelor degree midwifery programmes as a 'pilot scheme' at universities and colleges. Subsequently, higher education institutions offered (1) direct-entry study of midwifery and/or (2) an academic 'add-on' for licensed midwives. Since then academic midwifery programmes have been established at only 10 higher education institutions, whereas the diploma midwifery education is still offered at more than 50 hospital-associated schools. However, Germany is required by the European Union to harmonise its midwifery education with European law; the entry requirements for midwifery education have recently been changed to 12 years of general education for this reason. This also means that midwifery education as a whole must be upgraded to an academic level by 2020 when the pilot scheme ends.

In Germany, women are legally entitled to avail themselves of midwifery care during pregnancy, birth, the first 8 weeks post partum and until weaning, the cost of which is covered by the statutory and private health insurance companies (Social Law: § 24 SGB V). Women with physiological (low-risk) and high-risk/complex pregnancies may directly contact a caseload midwife without a doctor's referral. Caseload midwives in Germany are entitled to work independently from obstetricians or medical doctors. They typically care for healthy women in the postpartum period in their own homes. Some caseload midwives also offer antenatal care and care for homebirths, in a birth centre or in some instances in a hospital.

Midwives are entitled to provide sole care during physiological labour, birth and the postpartum period, as laid down in the national midwifery law (Hebammengesetz, 1985) and according to the European Directive 80/155/EWG. In case of pathological developments or emergencies in pregnancy, childbirth and the postpartum period, midwives are required to advise women to contact an obstetrician or to call for immediate medical aid.

Obstetrician-led antenatal care has been regarded as the norm since the 1960s and 70s, when there were very few caseload midwives and health politics favoured medical obstetrical practice. Caseload midwives have only been entitled to provide antenatal care without consulting a doctor and to be remunerated by health insurance companies since 1986. However, they are required to advise pregnant women to have three ultrasound scans, as specified in the directives for maternity care ('Mutterschafts-Richtlinien'). Interprofessional cooperation between midwives and obstetricians in the antenatal period is mostly limited to the pregnancy 'passport' ('Mutterpass'), in which both record their findings. Whereas few midwives are contacted for antenatal care, caseload/freelance midwives, or those working part-time in hospital and part-time freelance, are the main healthcare providers in the postpartum period after discharge (Sayn-Wittgenstein, 2007).

Hospital births have for many decades accounted for about 98% of all births. As members of an *interprofessional team* bound by hospital policies, midwives working in hospital are generally required to inform an obstetrician on admission of a pregnant woman, and to advise of the impending birth, even when all health parameters are within normal ranges. On the postnatal ward women are typically cared for by nurses with no additional obstetrical training. Hospital care for childbearing women is therefore fragmented and they are attended to by different professions and healthcare professionals across different shifts. New mothers are entitled to a total of 36 home visits after discharge from hospital by caseload midwives over the first 8–12 weeks at no cost. In the end, the frequency is determined not only by the women's needs, but by a regional lack of midwives and/or unavailability of specific midwifery services.

With regards to professional regulation, there is no national regulating institution, and therefore no systematic, representative and reliable data of the estimated 22,500 midwives, and particularly of caseload midwives. Annual data collection on non-hospital births by the association for quality in out-of-hospital births (Loytved, 2016), for which reporting was initially voluntary, is now part of the requirements pertaining to aspects of quality assurance in the remuneration contracts between health insurance companies and the midwifery associations, of which the Deutscher Hebammenverband (Deutscher Hebammenverband e.V. und Spitzenverbände der Krankenkassen, 2015; www.hebammenverband.de) is the largest. The latter also negotiates the compulsory liability insurance for midwives, the annual premiums of which (for out-of-hospital births) in 2017 amounted to more than 7000 Euro.

State of research in Europe

A literature search in the databases Medline, Psyndex, CINAHL, Scopus and MIDIRS was performed in February 2017 in order to appraise the present state of research with regards to the subjective experience of midwifery care within Europe. Although the national health systems in Europe differ, the harmonisation of midwifery education and mutual recognition of midwifery qualifications by European states based on European law justifies the limitation of the literature search to Europe. Inclusion criteria were: interpretative hermeneutic studies or surveys with open questions. The search was limited to research published in English or German. Studies were excluded if they evaluated only specific programmes or single interventions by midwives. The search was conducted using the (truncated) keywords 'perception, perspective, view, experience, encounter, midwife, midwifery OR maternity care' in the title AND 'role, advocate, facilitation, support, promotion, normal birth OR physiological birth' in the abstract and combining them with the respective Boolean operators.

Six studies remained after application of the inclusion and exclusion criteria (see Fig. 1). Their combined knowledge base will be presented as follows: a) supporting physiological processes in childbirth; b) comprehensive and high-quality midwifery education; c) favourable environment for the provision of midwifery care.

a) Supporting physiological processes in childbirth

Being committed to fostering physiological processes during pregnancy, birth and the postpartum period, midwives act as women's advocates when they are unable to voice their wishes and expectations in the clinical setting (Hadjigeorgiou and Coxon, 2014). However, midwives are faced with situations in which they cannot live up to their aspirations, which negatively impacts on their work satisfaction. One important systemic factor is the strict hierarchical structure of healthcare systems with doctors on top, leaving midwives and women with rather limited scope for decision making (Keating and Fleming, 2009; Van Kelst et al., 2013; Hadjigeorgiou and Coxon, 2014). In the Netherlands, for example, known for high rates of out-of-hospital births, a change of paradigm seems to be occurring, resulting in a role conflict for midwives: women in labour increasingly prefer to anaesthetise and expunge the pain of giving birth, whereas midwives want to support them to cope with it. As they cannot provide this in the homebirth setting, midwives are forced to refer/transfer women to hospital (Klomp et al., 2016).

b) Comprehensive and high-quality midwifery education

In Cyprus midwives see the reason for the lack of recognition of their profession and their expertise in prevailing deficits in midwifery education. Midwifery students are not sufficiently prepared to act in the interests of the women they care for, especially in the context of medicalised maternity care (Hadjigeorgiou and Coxon, 2014). Belgian midwives criticise the prevailing hospital care resulting in cascades of interventions and thus hampering provision of core midwifery practice (Van Kelst et al., 2013).

c) Favourable environment for the provision of midwifery care

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