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11 Transition to Practice for Newly Qualified Midwives in the Netherlands

Esther Feijen-de Jong and Liesbeth Kool

Abstract

In the Netherlands newly qualified midwives (NQM) have to work in practice, without formal mentorship and support. Midwives are fully qualified, autonomous medical professionals when they complete their bachelor's degree. Dutch NQM depends on informal support systems, mostly provided by colleagues and peers. NQMs seem to initiate informal support by themselves. For primary care NQMs, colleagues are sometimes employers and therefore not always safe for deliberating their questions.

Keywords

Dutch NQMs · Midwifery-led care · Legislation · Autonomy · Informal support · Colleagues · Peers

11.1 Introduction

In the Netherlands, midwifery is integrated in a remarkable healthcare and educational system. Dutch newly graduated midwives have to function as autonomous medical professionals within this health system. In this chapter about midwifery in

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the Netherlands, we start off with a brief summary of the history of midwifery, followed by a description of the midwifery educational system and a section providing information about the registration and regulation of new midwives. Finally, mentorship and support for newly qualified midwives will be discussed.

11.2 History and Context of Midwifery Practice in the Netherlands

11.2.1 Legislation of Midwifery, the Birth of an Autonomous Medical Professional

In the Netherlands, legislative developments in 1865 laid the foundation of modern midwifery practice. By law it was determined that midwives were only to attend such deliveries that were the work of nature or which could be done by hand (van Lieburg and Marland 1989). This meant that this law forbade midwives to attend "abnormal" deliveries. If complications arose during a birth, the midwife was to summon a physician. Because of this law, training for midwives was also regulated resulting in the establishment of two midwifery academies, respectively, in Amsterdam (1865) and Rotterdam (1882). The result was the formation of a professional group secured by legislation, licensing, and training facilities. On the other hand, it was also the beginning of a more rigid definition of the role of midwives during birth. All difficult cases were to be transferred to or supervised by a (usually male) medical attendant (van Lieburg and Marland 1989).

As the nineteenth century progressed, midwives established their own professional organization and journal (van Lieburg and Marland 1989). In the twentieth century, tasks and responsibilities of midwives were extended leading to the authorization of providing prenatal care that started from 30 weeks on (1932) (Schultz 2013). In 1951 midwives' responsibilities expanded even more; legislation was modified to extend responsibilities to include the provision of care during the whole pregnancy and during birth including the suturing of perineal tears (Drenth 1998). Before 1951, if a woman needed suturing, midwives had to call a general practitioner. Nowadays, midwives have the responsibility for women in the reproductive age including prepregnancy, prenatal, intranatal, and postnatal care. However, the scope of midwifery within perinatal healthcare is still related to the definition of the law of 1865.

11.2.2 Place of Birth

Up to the 1960s, Dutch women preferred to give birth at home (Schultz 2013). The main reason for the high rates of home birth during this period was the lack of hospital facilities for maternity care and birth (van Lieburg and Marland 1989). After this period, so-called polyclinic deliveries were introduced. Polyclinic deliveries are deliveries in which women give birth accompanied by their primary care midwife.

This also leaded to the increase of hospital births from 22% in 1953 to 71% in 2008 (CBS 2009). Up until now women have to pay a fee if they decide to have their baby in the hospital (in 2018 €342) (i.e., when there is no medical reason to deliver in the hospital). The tradition of giving birth at home is fading away resulting in the declining home birth rates from 70% in 1970 to 13% in 2016 (Kenens et al. 2017; Perined 2018). Social-cultural explanations given for the declining rates of home birthing are the changing economy, immigration, and increased interaction with other cultures via media and travel, which have altered ideas about birth, healthcare, family, and roles of women (De Vries et al. 2013).

11.2.3 Birth of the Hospital Midwife

As mentioned above, in the early 1970s, women began to prefer to deliver their babies in a hospital. The number of polyclinic births increased as well as medically indicated births. At that time, hospitals also employed midwives in a clinical hospital setting in order to maintain physiology in a setting where many medical interventions were used. Midwives liked working in hospitals because of the better work environment as compared to the work they did in home birth settings. A new midwife was born, the hospital midwife (Kenens et al. 2017; van Lieburg and Marland 1989; Schultz 2013). Hospital midwives are primarily involved with relatively uncomplicated medically indicated births (Wiegers and Hukkelhoven 2010). The proportion of hospital midwives in the Netherlands has increased to 28% in 2016 (Kenens et al. 2017).

11.2.4 Organization of Midwifery Practices and Maternity Care

Until the late 1980s of the last century, most of the midwives worked in solo practices (67.6%) taking care of 165 caseloads a year. In 2016, only 5% of all midwives worked solo—with a caseload of 105 (Kenens et al. 2017). Nowadays, the majority of primary care midwives (80.4%) work in group practices of three or more midwives (Kenens et al. 2017). This move to group practice has been a strategy for primary care midwives who wanted to create a more balanced private life (Warmelink 2017). Midwifery practices have a specified working area to guard timely care. They offer prenatal consults during the week and have a midwife on call 24/7 (KNOV).

Dutch maternity care has been split into primary, secondary, and tertiary care, similar to the overall organization of the Dutch healthcare system (Feijen-de Jong 2015). Primary maternity care is provided by primary care midwives and by some general practitioners for normal physiological pregnancies (low-risk pregnancies). Midwives and general practitioners attend and supervise a large proportion of births, falling from 60% in 1910 to 30.5% in 2012. In 2012, 85.4% of all pregnant women started maternal care in primary care (0.4% with the GP). These women received the care of a total of 2692 midwives (Feijen-de Jong 2015). Secondary/tertiary

maternity care is provided by obstetricians or residents and secondary care midwives working under the responsibility of obstetricians (high-risk pregnancies). The costs of secondary care are reimbursed by healthcare insurance companies exclusively for medical reasons. An Obstetric and Midwifery Manual—which is acknowledged by all primary and secondary care providers—is used to optimize risk selection and referrals from primary to secondary care (De Geus 2012).

11.3 Midwifery Education: Preparation for Practice

In the Netherlands, the Ministry of Education, Culture and Science is in general responsible for the financing of the education system, defining the general education policy, and specifying the admission requirements, structure, and objectives of the education system (Nuffic 2015). Higher education in the Netherlands has a binary system, different from many other countries in Europe. A distinction is made between research-oriented education (academic level) and higher professional education (applied science). Both types of education have different objectives and have their own admission requirements, program duration, and titles.

Midwifery education falls in the higher professional education (applied) category, a 4-year bachelor program. Midwives are fully qualified professionals when they complete the bachelor's degree. After taking the Hippocratic Oath, newly graduates have to register themselves at the BIG-register. The BIG-register arises from the BIG Act (in Dutch: 'Wet op de beroepen in de individuele gezondheidszorg'; Individual Healthcare Professions Act) (Ministry of Health, Welfare and Sport). From then on, they are legislated to work as a midwife in the Netherlands.

The academies in the Netherlands are strictly bound by the government by the amount of students they permit to enter the midwifery education. The inflow and outflow of midwives in the Dutch workforce are measured every 2 years (Kenens et al. 2017). Every year about 200 students are selected to enter Bachelor of Midwifery.

After the bachelor program, midwives can enter a Master of Midwifery program. These Master of Midwifery programs exist on two levels: professional higher education (Master Physician Assistant) and on academic level (Master Midwifery Science, European Master Midwifery Science).

11.3.1 Midwifery Education in the Netherlands

Since 1818, the education of midwives consisted of at least 1 year of education in the theory of midwifery. Following the theoretical underpinnings, the midwifery student would undertake an apprenticeship with a licensed midwife. Up until 1913, there were two regional schools and one city school for midwifery in the Netherlands: regional schools in Amsterdam, since 1861, and in Rotterdam, since 1882, and a city school in Groningen, which closed in 1912. In 1913 the Roman Catholic College of Motherhood founded a program in the south of the Netherlands (Heerlen)

with a 2-year training course for midwifery (van Lieburg and Marland 1989). Finally, in 2001, the Midwifery Academy of Amsterdam decided to start a new academy in Groningen, 90 years after the closure of city school.

From 1994, midwifery education became a 4-year Bachelor's degree program. Students did not have a degree in nursing, which means that the program was (and still is) direct entry (https://www.verloskunde-academie.nl/geschiedenis/).

Midwifery education in the Netherlands was, until 2008, one of the last educational programs embedded in the Ministry of (VWS) Health, Welfare and Sport. In 2008, midwifery education was brought under the Higher Education and Scientific Research Act (WHW). With this change in 2008, the four academies of midwifery in the Netherlands, previously autonomous organizations, had to become part of the Universities of Applied Sciences. All academies chose for an additional alliance or close cooperation with a full University in order to develop research program in midwifery science.

To maintain the strong autonomous position of Dutch midwives and the high level of care for low-risk women, the academies as well as the Royal Dutch Organization of Midwives declare the importance of empowering midwives by training them academically to a high standard. When the Ministry of Health, Welfare and Sport rejected this request in August 2011, the AVAG Midwifery Academy (Academy Midwifery Amsterdam and Groningen) looked at various ways of implementing midwifery training within the framework of research-oriented higher education.

The legal framework for midwifery education is represented in different pieces of legislation: the Individual Healthcare Professions Act (known in Dutch as the BIG Act) (Department of Justice 1993) November 11, 1993; the Higher Education and Research Act (WHW) (Department of Education 1992; Department of Justice 1993) October 8, 1992; and the Order in Council passed by the Ministry of Health, Welfare and Sport in 2008 as part of the BIG Act. The professional and educational framework trace back to international standards of the profession, as defined by the ICM (International Confederation of Midwives 2011). The educational framework is also based on the profile for integrated midwifery care approved by the Global Standards for Midwifery Education, the Royal Dutch Organization of Midwives (KNOV), and the national training profile approved by the Association of Dutch Midwifery Schools (SOV). The educational program is based on the core qualifications for Dutch higher professional education (Nuffic 2015) and the Dublin descriptors in the Framework for Qualifications of the European Higher Education Area (Bologna working group 2005), which are requirements for all educational programs within higher education.

11.3.2 Competencies of a Midwife in the Educational System

The three midwifery programs (Maastricht, Rotterdam, and Amsterdam/Groningen), through the SOV (Collaborative Education Midwifery), have developed a national profile for midwifery education. This profile is congruent with the national occupational profile developed by the Royal Netherlands Organization of Midwives (KNOV) (Aitink et al. 2014). The national profile for midwifery describes the requirements, the professional qualifications, which one has to

master to exercise the profession for which the student is trained. A national training profile sets out the common learning outcomes for the Netherlands, with skills that the student has to acquire during the program, enabling her to become an independent, skilled professional in practicing midwifery. The competency level of newly graduated midwives differs from other graduated healthcare professional on higher education level. There are higher levels required in terms of independent occupational practice and the evidence base of the profession: the practice of midwifery in the field of reproductive care and the competencies to practice this in an evidence-based manner. Regarding the organizational competencies such as administration and entrepreneurship, NQMs work at a starting level of the profession, which is similar with other professions on the higher professional education level.

In accordance with the Royal Degree Training Requirements (Nederlandse Overheid 2008), the program of 240 European Credits (EC) includes 100 EC of internship in the professional practice, of which 60 EC are in community practice: known as primary midwifery care. In addition, in order to graduate, a required number of specific "obstetric procedures" have to be performed. For instance, to graduate, a student must have supervised a total of 60 deliveries, of which 30 occur in primary midwifery care. Some of these "obstetric procedures" are restricted, designated as such in the BIG Act (Department of Justice 1993) November 11, 1993, for instance, performing episiotomies or suturing perineal repair.

In the formulation of the national profile of midwifery education, the statutory guidelines for the European Union (EU) are included in the level of traineeships and the number of performances. These EU directives therefore indirectly form part of the legal framework used by the courses (Council Directive 2005/36/EC on the mutual recognition of diplomas, certificates, and other evidence of formal qualifications in midwifery).

In conjunction with the national occupational profile (Aitink et al. 2014), the national educational profile consists of four domains in which the midwife exercises the various roles—namely, the role of medical expert and the other six roles associated with the seven CanMEDS roles in medical education (The Royal College of Physicians and Surgeons of Canada 2015). Each role has a number of competencies. The four domains a midwife is working in consist of (1) reproductive care in social, demographic, and cultural context of maternal and newborn care, prepregnancy care, and family planning, care during pregnancy, care during labor and birth, care for women during the postpartum period, care of the newborn, and facilitation of abortion-related care, (2) organization of midwifery care, (3) scientific basis of the profession, and (4) professionalization of the profession.

11.3.3 An Example of a Dutch Midwifery Curriculum

The curriculum of the midwifery academy Amsterdam Groningen (AVAG) 2014 is a newly developed educational program, sparked by the changes in the maternity

care system in the Netherlands. It builds on the changes in the organization of care involving integration of primary and secondary care that can contribute to improved collaboration. All those involved in this process also believe that integration of the various levels will improve the quality of care. Furthermore, AVAG has added its own ambitions for their educational program: learning high-level academic skills and a feasible, attractive curriculum at both locations.

Competencies, as derived from the national profile, are formulated in 16 different qualifying tasks. These tasks require proficiency in multiple competencies and qualify for entrusted professional autonomy. If a student meets these qualifying tasks, she is ready to work in practice. The performance of the tasks laid down in the final qualification tasks shows that a student has all the competencies demanded by the professional profile. The curriculum is constructed along five vertical leaning tracks, to ensure consistency in the program.

Parts of the educational program are internships, in primary and secondary midwifery care as well as in research and public health. Internships allow students to take the knowledge and skills they have acquired and incorporate these into their professional conduct. Workplace learning predominates in the second half of the program. Students learn on the job training—or, in more formal term, they develop competencies that become an integral part of their professional activity.

The Bachelor's degree in higher professional education consists of a major (210 EC) and a minor (30 EC). A minor is a period of study in another area of education. For the AVAG this can be a period of study within a research university. The minor period gives students the opportunity to study certain topics related to the field of midwifery in greater depth. Students have the opportunity to choose a minor as proposed by AVAG (offered are research, health science, health communication, ethics, and policy) or to draw up a plan for a minor of their own choice, in the Netherlands or abroad.

11.4 Registration and Regulation of Midwives

Midwives, graduated in the Netherlands as well as graduated midwives from other EU countries, are legislated by the Individual Healthcare Professions Act (BIG Act) (Department of Justice 1993) November 11, 1993. This act regulates the qualification of healthcare professionals wanting to practice in the individual healthcare sector. The BIG Act imposes rules for healthcare professions and protects patients against incompetent and negligent acts. The BIG-register includes physicians, dentists, pharmacists, health psychologists, psychotherapists, physiotherapists, midwives, and nurses. In order to be registered in the relevant register, the possession of a certificate stating that the person concerned meets the training requirements set for this purpose is required. Midwives may practice in midwifery and undertake other actions aimed to promote and monitor the normal course of pregnancy, childbirth, and the early postnatal period. Next to that, preventing maternal and perinatal complications by assessing the woman during pregnancy, childbirth, and first week postpartum, assessing the obstetric risk in obstetric policy, and the provision of advice and assistance as well as to consult or refer to a physician when necessary.

Apart from the legislation via the BIG Act, the Dutch Royal Organization of Midwives (KNOV) has its own quality register for midwives. The aim of this register is to show whether a midwife practices in accordance with the professional standards and invests in expertise. A midwife must demonstrate the following as per the criteria for registration: 10 h a week practicing as a midwife in every 5-year period, ability to demonstrate that she works according to the midwifery standards, participating in a complaint scheme that complies with the Quality, Complaints and Disputes Care Act (CHP), and participating in (accredited) lifelong learning activities (200 h/5 years). Registration is not compulsory, but around 80% of all midwives have registered so far.

The KNOV has also initiated a register for midwives who have advanced training and experience in external cephalic version (ECV) of the fetus (Register Verloskundigen Basis Echoscopie). Nearly 100 midwives have registered so far. To maintain her registration, a midwife has to perform a minimum of ten ECVs each year.

For hospital midwives, the Royal Dutch Organization of Midwives has conducted a supplementary profile. A steering committee with members of the KNOV and the Dutch association of obstetricians and gynecologists (NVOG) has been formed to formalize the position of the clinical midwife in legislation. Moreover, they want to determine the role and position of the clinical midwife; therefore, a specialist's register is required. Only midwives who have completed a professional Master's education will be able to register in this specialist's register.

11.5 Newly Qualified Midwives

As mentioned in the previous paragraph, newly graduated midwives (NQMs) are trained to work as a competent practitioner from the point of graduation. Before graduation, they always work under supervision of a qualified and experienced midwife. All midwives, including those newly graduated, work autonomously in primary midwifery care. They have the responsibility for women in the reproductive age including prepregnancy, prenatal, intranatal, and postnatal care. After graduation, no further mentorship is formally required.

In the Netherlands, over the years, changes in employment and working place have been visible. For instance, in 2015, 74% of new graduates were working as a locum in primary midwifery care (Kenens et al. 2017). This is very different to 1987, when zero percent of the NQMs worked as a locum. From 2007 on, there is a clear trend for new graduates that they work as locum midwife (from 6 to 74%), as explained in Textbox 11.1 (Kenens et al. 2017).

Textbox 11.1 Explanation of Working as Locum in Midwifery in the Netherlands

Locum midwives are self-employed. For the government and taxes, they are so-called self-employed without personnel (ZZP). Midwives working as replacement for a midwife in primary midwifery care are called locum midwives in the Netherlands.

Primary care midwives, working in a practice in the community, hire a locum for their holidays or when they are ill. To employ a locum, there are no hierarchic relationship whatsoever and no need for long-term employment.

NQMs working in a hospital setting varies from 7% (2015) to 28% (2010) (Kenens et al. 2017).

11.5.1 Support for Newly Qualified Midwives

After graduation, NQMs tend to work autonomously as (locum) midwife in practice. Formal support systems for these new graduates do not exist in the Netherlands. NQMs are educated to work autonomously and are fully accountable for their actions and decision-making in practice. NQMs usually have to rely on informal support, mostly by colleagues and peers.

As illustrated in the textboxes below, NQMs experienced the first months as tough and highly demanding. Support is depending on the goodwill of their colleagues or the arrangements they made by themselves. Stories about support NQMs' experience in the first period of practice are derived from interviews with NQMs in the Netherlands (Kool et al. 2018).

The NQM in the textbox is telling about the kind of support she experienced with colleagues and peers.

> With colleagues, so to say, I could mention: this is what I did, so I could check her point of view. This was more colleague like deliberation instead of her telling me what to do. But anyway, when I came home I was thinking: did I do the right thing? And then I made a call to my friend (also a NQM), and we talked, and then I could let it go and go on with my life. Nevertheless, I think it was nice to work on my own. Although, this first period in practice was very stressful. I could describe it as a turbulent period. Different emotions came up. Physically, I became aware that I have to learn to take care of myself as a midwife. Because if you do not, than it will go wrong, that you can face your own pitfalls. And mentally, at work I felt all right, but when I came home, I collapsed. Then the emotions came up. When I was at home, I cried a lot. Afterwards, when then tears were gone, I felt relieved. And the next day, I felt all right, and I felt that I could do my job. And my shift went well and when I came home, I cried again. At home, for my boyfriend it was a year with a river of tears.

For NQMs, colleagues, peers, and family seem important informal sources of support. Family members at home are important for sharing emotions, food, and sleep. For locum-working NQMs, peers are experienced as safe and trustworthy sources of support.

> A friend of mine who graduated as a midwife a year previously was also working as a locum midwife. I have contacted her very often, by phone or WhatsApp, and asked her: can I discuss something with you? That helped me a lot. In hindsight, I should have asked more support from colleagues. But I

did not do that. I wanted to prove myself. I was thinking: “I am graduated and I will not contact my colleagues on daily basis with minor issues.” Then I contacted my friend. She did not mind my questions. She recognized the need for support and the feelings of insecurity about decisions. That helped me a lot. For me she was a kind of buddy.

Colleagues in primary midwifery care seem to be a very important source of support; however if these colleagues are employer as well, it is less safe for NQMs.

When I just started working as a midwife in practice, we arranged a colleague available for questions, for the first 1 or 2 months. That I always had someone to be able to call during my shift, to talk through something. A kind of help line, which was very reassuring for me. I only used it twice, but knowing that you could phone someone to chat it through. Even that is already very pleasant, I think. I had really learned to solve things for myself. So what I now tell a graduate, for example, a locum that I work with now, I say: Hey, phone me. It does not matter if you cannot work something out by yourself, because I know that it is nice if someone is backing you up. That there is someone who you can contact with upcoming questions. Even if you need the support a few times, it is pleasant knowing it is available. And even if I did not have that kind of support. I learned a lot very quickly, because I just had to do it all myself, but that was a tough process. It was a kind of: you do your job and you are on your own if you manage, you never hear whether you do it right.

In a hospital setting, NQMs seem to have other informal support. The urge for support from peers seems less as compared to primary care NQMs. Hospital midwives work in a team setting. Next to that, they mention the difference in care they deliver with their peers, which are most of the time working in primary midwifery care. NQMs working in a hospital setting are working in a team. Deliberating care seems more common in a hospital setting. Informal support is most of the time available at the workplace. As one NQM in the textbox below stated:

For me as a midwife, the hospital (place) is a nice work setting. I like having a lot of contact with colleagues and that I can consult them if necessary. When I started at the hospital, I felt very welcome. In the hospital setting (secondary midwifery care), you have a lot of contact with colleagues. In primary midwifery care, you often work alone, when you are on the road and when you are taking care of clients at their home.

Colleagues brought me a lot of knowledge. They supported me with decision-making. They said: “What would you do if you have a client with

these problems. Or what do you think of this if this is the result from the laboratory?" And if I did not knew the answer, they told me that I just have to learn from situations on that subject. They knew that I was just starting as a midwife, and they really liked teaching me, even when I just did not know how to act. They had a lot of patience with me and told me that this was just a normal phase of getting to know the procedures and routines in practice.

Colleagues supported me. If I ran into something or I could consult them or I could deliberate my decisions of situations I met. And it was nice that we sometimes could laugh too when we had a night shift: having a bit of fun. They (my colleagues) also helped me to further develop myself.

In the hospital where I worked, fortunately the gynecologist was always available 24/7 h a day. You actually discuss every patient at different times during the shift. And it just gives the opportunity to make decisions together. When I worked in primary midwifery care, I felt more alone making decisions.

Organizing support from colleague midwives requires sometimes a proactive behavior. In the textbox below, a NQM is telling a story about how to organize feedback from colleagues.

When I was working in a hospital setting, I just missed my colleague midwives. The first months, I did not know them. And I was not able to get to know them, because we did not work together at the same shifts. I never saw them at work, except for one colleague who supported me the first weeks on the ward. I had expected that I could learn from colleague midwives when working together, but that was not the point. I knew their names and did recognize their faces, but I did not know who they were as individuals. There were some issues going on at work. Issues I had not met previously, for example, patients asking for care outside the regular care standards. I was taking care of patients with special expectations, and I did not know how to deal with this kind of expectations. So these were situations I wanted to deliberate with colleagues. For that reason I asked several colleagues, who were in my opinion open to questions, to meet on monthly basis for a kind of consult meetings. In these meetings, we can discuss situations with clients/patients, and we can deliberate how to cope with specific needs of clients. And if you want to discuss your own questions or situations, I would like that. I need some feedback from colleague midwives, because I do not meet them at work and I actually do not see them performing. And they are willing to meet on a regular basis. We had scheduled different meetings, and I did like these meetings very much.

11.6 Current Research on NQMs

Up until 2017 no research has been performed regarding the transition of midwifery students into practice. However, in 2017, a research team started to study the job demands, job resources, and personal resources perceived by NQMs at the workplace and their well-being the first years after graduation. In 2018, the first results regarding the work characteristics perceived by NQMs in primary and secondary midwifery care are expected to be published. In addition, the well-being of NQMs in the Netherlands will be explored (results expected in 2019). Finally, an intervention for Dutch NQMs will be developed and evaluated. This intervention will aim at facilitating the well-being of NQMs during the transition period (expected in 2021). The ultimate aim of this research project is to improve maternal and perinatal outcomes and to prevent attrition from the midwifery workforce.

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