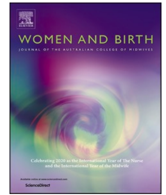
Women and Birth 37 (2024) 101663

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth



Working in smaller teams in community midwifery practices to foster continuity of carer: Midwives' experiences – A qualitative study in the Netherlands

Marcelle van Wijngaarden[a,*], Hinke Blonk[a], Renate Simmelink[a,b,c,d], Nadine van der Lee[e], Hanneke Harmsen van der Vliet-Torij[f], Marianne Nieuwenhuijze[g,h], Ank de Jonge[a,b,c,d], Corine Verhoeven[a,b,d,i,j,k]

[a] *Midwifery Academy Amsterdam, the Netherlands*
[b] *Amsterdam University Medical Center, Location VUmc, Department of Midwifery Science, Amsterdam, the Netherlands*
[c] *Amsterdam Public Health, Quality of Care, Amsterdam, the Netherlands*
[d] *University of Groningen, University Medical Center Groningen, Department of Primary and Long-term Care, the Netherlands*
[e] *Spaarne Gasthuis, Haarlem, the Netherlands*
[f] *Rotterdam University of Applied Sciences, Research Center Innovations in Care, Rotterdam, the Netherlands*
[g] *Research Centre for Midwifery Science, Zuyd University, Maastricht, the Netherlands*
[h] *Care and Public Health Research Institute, Maastricht University, Maastricht, the Netherlands*
[i] *Amsterdam Reproduction and Development, Amsterdam, the Netherlands*
[j] *Division of Midwifery, School of Health Sciences, University of Nottingham, Nottingham, United Kingdom*
[k] *Department of Obstetrics and Gynaecology, Maxima Medical Centre, Veldhoven, the Netherlands*

ARTICLE INFO

Keywords:
Midwifery (MeSH)
Continuity of Care (MeSH)
Pregnancy (MeSH)
Maternal Health Services (MeSH)
Smaller teams
Midwives' experience

ABSTRACT

Background: Midwife-led continuity of carer (MLCC) improves health outcomes and increases pregnant women's satisfaction. Working in smaller teams in community midwifery practices is one of the ways to promote continuity of carer.
Aim: To gain insight into the experiences of Dutch community midwives regarding working in smaller teams, by identifying motivators and barriers.
Methods: A qualitative study was conducted using individual, semi-structured interviews (n=9). The sample was purposively selected. The interviews were analysed using the Abbreviated Grounded Theory.
Findings: Four themes were identified: 1) Ideal implementation of working in smaller teams, 2) Best care for pregnant women, 3) Conflicts with the current maternity care system, 4) Personal interests of the midwife. The core concept connecting all themes was midwives' experiences of an 'inner conflict' regarding working in smaller teams.
Conclusion: A strong motivation for working in smaller teams is the wish to provide the best care for pregnant women through offering more continuity of carer. The structure of maternity care, financially and organisationally, acts as a barrier in the transition to working in smaller teams. How community midwives manage these motivators and barriers depends on their personal interests, vision, and personal life. The balance between the motivators and barriers can create an inner conflict among the midwives. This inner conflict encompasses an ethical issue: what is the best care and what is it worth? A discussion within the professional group concerning the practical and ethical aspects of working in smaller teams is needed to find ways to reduce the inner conflict of community midwives who wish to work in smaller teams, thereby promoting the implementation of MLCC.

* Correspondence to: Midwifery Academy Amsterdam, Vlaardingenlaan 1, Amsterdam 1059 GL, the Netherlands.
E-mail address: marcellevanwijngaarden@gmail.com (M. van Wijngaarden).

https://doi.org/10.1016/j.wombi.2024.101663
Received 6 May 2024; Received in revised form 9 July 2024; Accepted 31 July 2024
Available online 17 August 2024
1871-5192/© 2024 The Authors. Published by Elsevier Ltd on behalf of Australian College of Midwives. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

Statement of Significance

Problem or issue

Midwife-led continuity of carer (MLCC) improves maternal and perinatal health outcomes. Working in smaller teams in community midwifery practices promotes MLCC. Despite the positive attitude of Dutch community midwives towards MLCC, they experience barriers to its implementation.

What is already known

Midwives experience both satisfying and challenging aspects when working in MLCC models.

What this paper adds

This paper shows the opportunities and challenges for midwives who want to work in smaller teams in a maternity care system with independent community midwifery.

Organisation of maternity care in the Netherlands

The Dutch maternity care system is based on a division between primary care in the community and secondary and tertiary care in hospitals [1]. In the Netherlands, pregnancy and birth are considered physiological processes that can be cared for in primary care, by community midwives in midwifery practices. Community midwives assess women and allocate their risk for adverse outcomes. In the case of medium or high-risk pregnancy or birth, the woman is referred to obstetrician-led secondary or tertiary care, provided by hospital-based midwives and obstetricians [2]. In 2021, 91.8 % of pregnant women started their antenatal care with community midwives [3]. During pregnancy, 47.2 % and during labour, 19.4 % of these women were referred to obstetrician-led care. Of all pregnant women, 25.2 % gave birth under the care of a community midwife. The current funding system in the Netherlands entails that community midwives are compensated per care episode (pregnancy, intrapartum and postpartum care) per client [4]. Community midwives in the Netherlands can work in group practices with one or more teams, or as a caseload midwife in a solo practice. The concept of working in smaller teams means working with fewer midwives in a team to reduce the number of midwives that women have to get to know.

1. Introduction

Midwife-led continuity of care entails the midwife being the provider and coordinator of care while prioritising women's needs and collaborating with obstetric and specialist teams when required [5]. Although midwife-led continuity of care involves several levels of continuity, we focus on the fundamental element of this model, which is called midwife-led continuity of carer (MLCC), and is described as either one midwife or a small team of midwives providing care to women throughout pregnancy, childbirth and the postpartum period. In this model, the midwife, being the continuing carer, is the lead professional from the initial booking appointment up to and including the early days of parenting.

A Cochrane review [5], including 17 studies with 18,533 mainly low risk women, indicates that compared to other care models, i.e. models of obstetric-led care, shared care and family doctor-provided care, MLCC results in significantly more spontaneous vaginal births (RR 1.05), fewer caesarean sections (RR 0.91), reduced episiotomy rates (RR 0.83) and fewer assisted vaginal births (RR 0.89). Furthermore, MLCC enhances women's satisfaction with care [6].

International studies demonstrate that midwives generally have a positive attitude towards the underlying values and concepts of MLCC, primarily due to the associated health benefits [7] and women's satisfaction [8]. However, attitudes toward implementing MLCC in their own practice vary, from a more positive to a more negative attitude [8–10]. This variation is due to midwives experiencing both satisfying and challenging aspects when working in MLCC models. MLCC has a positive influence on midwives' job satisfaction, with experienced professional autonomy and building meaningful relationships with women being cited as motivators [11,12]. Another study showed that community midwives working in MLCC models had lower scores on symptoms associated with burnout [13]. Yet, increased workload without adequate compensation in time or money negatively affects midwives' attitudes towards MLCC [8–10,14,15]. Regarding the demanding aspects of MLCC, midwives who did not engage in this model cited time constraints, inadequate staffing, and a lack of administrative support as barriers [16]. Other challenges of implementing MLCC include conflicts with medical institutions and professionals in standard models of care and disrupted work-life balance due to on-call duties [11].

In the Netherlands, community midwives are motivated to provide MLCC because they consider it important for both their own job satisfaction and the provided quality of care [17]. However, for some Dutch midwives, the impact on work-life balance is a barrier [17]. Also, qualitative research revealed that Dutch community midwives question whether they have the skills required for providing MLCC when referral to hospital care is indicated and obstetrician-led care is needed [18]. Moreover, various maternity care providers mentioned that the implementation of MLCC in the Netherlands is hindered by differences in opinion between community and hospital-based care providers regarding how MLCC should be organised [18].

Despite the positive attitude of Dutch community midwives towards MLCC, there are still barriers to its implementation. In the Netherlands, the COntinuity of MIdwifery Care (COMIC) project has been established to gradually implement MLCC. One component of this project is transitioning to working in smaller teams in community midwifery practices to reduce the number of midwives that women have to get to know and thereby promoting MLCC [19]. In other countries, providing MLCC by working in smaller teams has been implemented in different ways. For example, Australia, Denmark, and in the United Kingdom have introduced caseload midwifery, where a team consists of two midwives, with one acting as a back-up to the other [10,13,14,20]. According to England's National Health Services [21], MLCC can be delivered through caseloading as well as team midwifery, with teams consisting of four to eight midwives [9]. Although it is recognized that there are variations in team size, research on midwives' experiences has primarily focused on caseload midwifery in teams of two, providing limited insight into working in smaller teams.

Understanding the experiences of Dutch community midwives with the approach of working in smaller teams is essential for its successful implementation. The main research question of our study is therefore: What are community midwives' experiences with MLCC and, more specifically, working in midwifery practices with smaller teams in the Netherlands? Three sub-questions will be addressed: 1) What are the motivators and 2) the barriers of community midwives for working in smaller teams in midwifery practices? 3) How do community midwives cope with the motivators and barriers regarding working in smaller teams?

2. Methods

A descriptive qualitative study with an interpretative approach was performed to gain insight into the experiences of Dutch community midwives regarding working in smaller teams. Experiences were explored through individual, semi-structured interviews. The standards for Reporting Qualitative Research (SRQR) were used to report this study (Appendix 1).

2.1. Data collection

The inclusion criteria for all participants required them to be community midwives who either began working in a smaller team between 2012 and 2022 or had considered doing so. Participants were

interviewed individually by the third author (RS) via Microsoft Teams. Data were collected between 8 July and 22 November 2022. The selection of community midwives was an iterative process. Selection occurred both before and during data collection, to ensure a heterogeneous sample with differences in age, work experience, role within the practice, and stage of life. One participant responded to an online invitation to participate in this study, the other participants were purposively selected nationwide through the COMIC team's own network. Respondents provided verbal and written consent to participate in the research and could withdraw at any time. The interviews were anonymised and then stored in a secure environment. Only the researchers of the COMIC team had access to these data.

2.2. Data analysis

Before conducting the interviews with community midwives, a topic list was developed based on sensitising concepts considered relevant in the literature (Appendix 2). The digital recordings of the interviews were transcribed and anonymised. All interviews were closely read by three researchers (MW, HB, RS). An inductive analysis of the data was conducted using Abbreviated Grounded Theory [22], by coding the interviews in an open, axial, and selective manner to identify themes. MAXQDA software was used for the coding process. MW and HB coded two interviews together, using open coding. Subsequently, MW and HB separately coded the third interview. The codes from this interview were discussed by three researchers (MW, HB, RS). MW and HB then separately coded all other interviews. By axial coding, the codes where clustered in subthemes. Finally, by selective coding, the themes and the overarching core concept were identified and discussed by four researchers until consensus was reached (MW, HB, RS, AJ).

2.3. Researchers and reflexivity

During the study we considered how the researchers' attitude might influence the research. The involved researchers each had their own social position, experiences, and beliefs. The third author who conducted the interviews, also works as a hospital-based midwife. Being in this position, allowed her to maintain enough distance and an open attitude towards the considerations and opinions of the community midwives, while being knowledgeable on midwifery. The interviewer emphasised to the participants that she was conducting the interviews in her role as a researcher and not as a hospital-based midwife. Additionally, it was stated that all data would be anonymised, there were no right or wrong answers, and there was genuine interest in the different opinions. The first two authors were midwives in training with internship experiences in both community care and hospital care. Based on these experiences, the researchers had an ambivalent attitude towards the research topic. After each stage of coding, they reflected on the analysis process and how this might have been influenced by personal views. The reliability of the data analysis was enhanced by discussing the analysis process with the other authors.

Table 1
Characteristics of the participants (n=9).

	Characteristics	*n*
Age (in years)	<30	0
	30–40	1
	40–50	4
	>50	4
Gender	Female	9
	Male	0
Number of years practicing as a midwife	<10	1
	10–20	3
	20–30	4
	>30	1
Number of years practicing as a midwife in current community practice	<10	3
	10–20	4
	>20	2
Role within the practice	Practice owner	8
	Employee	1

3. Results

In total, nine midwives with variations in age, length of career, and stage of life, were interviewed (Table 1). Two midwives had considered working in smaller teams, but did not implement it in their practice. Most participants were over forty years old, owned their own midwife practice, and had been midwives for over ten years. The duration of the interviews ranged from 37 to 88 minutes.

Table 2 illustrates the characteristics of the midwifery practices where the participants were working. The majority were group practices with five to thirteen midwives. One of the midwives worked on a caseload basis at the time of the interview, and had worked in a bigger community practice earlier. The two practices that did not transition to smaller teams both consisted of a single, fixed team of respectively five and eight midwives, both with a workload size around the Dutch norm of 106 women per year per midwife. Conversely, the practices that were working in smaller teams typically consisted of two or three teams with two to six midwives per team, with a workload size of sixty to seventy pregnant women per midwife. In some of the smaller team practices, the size of the teams varied between antenatal and intrapartum care, or between weekdays and weekends. Some practices had a rotating midwife working interchangeably for different teams, or a midwife who, in addition to her duties in her fixed team, also provided caseload care for a number of women.

Four main themes emerged from the data regarding the experiences with working in smaller teams: 'Ideal implementation of working in smaller teams', 'Best care for women', 'Conflicts with the current maternity care system', and 'Personal interests of the midwife'. The core concept that connected all main and sub-themes was 'Inner conflict.' In Appendix 3, a table with the themes and their corresponding subthemes can be found. The themes are described with quotes for illustration. Participants' number is given in parentheses at the end of each quote.

Table 2
characteristics of the midwifery practices (n = 8).

Community practice of the participant	M1*	M2	M3	M4**	M5***	M6****	M7**	M8	M9
Number of midwives within the practice	13	9	1	6	12	5	6	8	5
Number of teams within the practice	5 / 2	2	1	2	4 / 2	2	2	1	1
Number of midwives within a team	2 / 6	4	1	3	3 / 6	3	3	8	5
Number of years working in smaller teams	3	10	5	1	20	UN	1	NA	NA
Workload size per year per midwife	UN	65	65	70	60	65	70	105	UN

NA: not applicable; UN: unknown.
* In this practice prenatal care is provided by 5 teams of 2 midwives and intrapartum care by 2 teams of 6 midwives and 1 team of 2 midwives.
** Midwife 4 and 7 work in the same practice.
*** In this practice prenatal care is provided by 4 teams of 3 midwives and intrapartum care by 2 teams of 6 midwives.
**** In this practice working in smaller teams is not applied during the weekend.

3.1. Ideal implementation of working in smaller teams

Midwives in our study have different views on the ideal way of implementing working in smaller teams, concerning the number of midwives, backup support, and the process of change. Midwifery practices that have transitioned to working in smaller teams consist of multiple small teams where women are allocated to one team. This results in women encountering fewer midwives during their care. Most participants mentioned that multiple teams of three to four midwives within a practice works best because sickness and holidays can be handled better than in teams of one or two.

> “…because I think you are very vulnerable when you are with two." (M6)

The process of transitioning to smaller teams varied in duration, with some practices taking only a few months, while others took years. The change was typically seen as an exciting and significant step. Some practices involved a mediator or external coach in this process.

> "…we didn’t receive any external help. If we were still one team now, I would definitely involve a coach now." (M5)

3.2. Best care for women

The pursuit of providing the best care for women is a shared motivator among midwives in our study. Supporting women’s autonomy and satisfaction plays a crucial role in this endeavour. Opinions vary regarding the best approach to intrapartum care.

Providing the best possible care is top priority for most midwives. They are consistently focused on how to improve maternity care in order to collectively provide excellent care for expectant mothers and families. All participants agreed that working in smaller teams promotes MLCC and this is also supported by their own experience.

> “…when we started working in two teams, our referral rate during labour decreased. We saw this for the use of pain relief and for prolonged labour. [.] when we compare our statistics with the statistics of our region, we really, really perform better.” (M6)

Midwives also mention that they are able to spend more time empowering women since they work in smaller teams.

> "…then you know that you simply have the time to work on that [their fear] with the women. [.] letting women experience that it’s just a natural process and that they can do it themselves [.] that they can lose that fear." (M1)

Furthermore, midwives said that for uncertain or anxious women, MLCC provides an extra sense of reassurance. Midwifery practices that did not transition to working in smaller teams still acknowledge the benefits of MLCC for vulnerable women. For instance, one midwife states:

> "We focus much more on looking at who you have in front of you and what that woman benefits from. And if that lady benefits from seeing only three different faces during pregnancy, then we try to arrange that." (M8)

Our participants indicated that there is a high demand from women for MLCC. Practices that have transitioned to working in smaller teams have a relatively small workload. This allows them to spend more time with women and to know their women better. Therefore, working in smaller teams strengthens the relationship between the woman and midwife.

> "We do notice that women are simply very happy with this, they say that during the postpartum check-up, or during labour [.]. We do have a stronger connection with the women." (M4)

The midwives in our study said that women are very pleased with the continuous support provided by smaller teams. Some did mention that they are under the impression that a known midwife is more important during the prenatal period than during labour.

> "…people always think, I want to have seen everyone so I know who will be there during the birth, while in the end, if someone else comes who they haven’t seen, it doesn’t matter to them at all." (M5)

Additionally, the autonomy and needs of women play a significant role for most midwives, such as women’s choice to potentially see more or fewer midwives during pregnancy.

> "It’s not about me, [.] but it really is about what the woman wants." (M3)

Working in smaller teams with a smaller workload size creates more time, allowing midwives to stay present during labour and birth after a referral to the hospital.

> "We try to finish as much [stay present during labour and birth] as possible. And again, we can do that because we have fewer full-term pregnancies per team. If there are three [other women] banging on the door as well, of course, you wouldn’t do that." (M1)

One participant mentioned that MLCC is more often provided in community-based care than in hospital-based care which may be the reason why many women express a preference for being attended by a community midwife. Another participant said that she often hears from women who gave birth in obstetrician-led care that they felt alone. Some community midwives expressed that they see themselves as the most suitable person to be the continuous factor during childbirth.

> "You joined when someone was actively in labour, and then you stayed until the end. Then you really saw the importance of that continuous factor [.]. Also in terms of processing and perception, and of course, you are the continuous factor, you know those people very well [.] I have always stayed with women." (M3)

3.3. Conflicts with the current maternity care system

Midwives stated that working in smaller teams is in conflict with various aspects of the current Dutch healthcare system: community midwives in the Netherlands are compensated per woman rather than per hour; and the current compensation structure is based on a workload size of 106 women per fulltime midwife per year. Consequently, working in smaller teams with a reduced workload size results in an income below the norm, even when the midwife works full-time, because they spend more time per woman. This financial impact is experienced as significant and challenging by midwives.

> "less income for more days of work. [.] the fact that you have less income, I think that’s difficult." (M1)

The feeling of having to work more despite a smaller workload size was emphasised by the participants. While the workload may decrease, certain responsibilities, such as on-call duties, are distributed among fewer midwives.

> "Well, what you of course run into as an on-call midwife is, I get to be on call twice as often, I have a 24-hour shift twice as often, where I have to be on call for 24 hours, it just feels like you have to work harder for less money." (M4)

All participants share the opinion that the current maternity care system is not yet structured to accommodate working in smaller teams. To achieve this they suggested that policymakers need to have a deep understanding and appreciation of MLCC, which midwives feel is not the case at present.

> "I do know where the problem lies. It’s how this world is structured, you know, that there are a few people at the top, who have mostly

spent a lot of time in classrooms, but haven't gotten their hands dirty, thinking they can sort it out for us. Yeah (sighs), that doesn't work." (M6)

These policymakers are the ones responsible for establishing the norm of workload size and compensation rates and who can provide support for working in smaller teams.

"…only if you have good people who can arrange it [changes in policies, e.g. changes in rate setting] […] then you can do this." (M3)

The midwives emphasise the role of community midwives in explaining the significance of working in smaller teams to policymakers. They stress that providing data on the health outcomes associated with working in smaller teams is crucial.

"…the Dutch Perinatal Database, should make it so clear that policymakers also see that it's worth it. Because then you have evidence to convince the insurance companies, to convince the politicians." (M6)

The current state of the national midwifery registration is not optimal. Therefore it is unclear, for example, how many teams operate within one practice. One midwife highlights the limitation of statistics:

"…and we have far too few statistics. That's why it's also good to participate in research, and fortunately, midwives are more and more coming up with research data and results. [.] we have to stand up for it and make our voices heard." (M3)

Midwives mentioned that the current Dutch health care system influences the extent to which MLCC can be provided. When a referral to the hospital occurs during labour, the hospital will receive funds, regardless of whether the community midwife stays present after the referral and does part of the work. In the fee for a birth that the midwife receives, it is included that she refers a certain number of women to the hospital. She is then no longer responsible for their care, and the fee does not account for the midwife staying with these women. For this reason, some midwives choose not to stay present after a referral to obstetrician-led care, thus disrupting continuity of carer.

The participants mentioned that quality of the multidisciplinary collaboration is a significant factor in providing MLCC. A good multidisciplinary collaboration enables MLCC, which is appreciated by the community midwives.

"…how we work in a very approachable manner with the obstetrician and then maintain continuity there. Yeah, I still really appreciate that." (M2)

Another organisational factor affecting the sustainability and feasibility of working in smaller teams with a reduced workload size is the capacity problem in the Dutch maternity care system and the shortage of midwives. As one midwife, who does not work in smaller teams, mentioned:

"…if we put a stop on our practice, where will they [the women] go? Where will they go if we accept care for fewer women? It's already difficult now, so in the end it feels like the problem will just shift." (M8)

Midwives in our study believe that addressing this capacity issue requires an increase in the number of midwives.

3.4. Personal interests of the midwife

How a midwife experiences working in smaller teams and whether she is willing to implement it also depends on the characteristics of the midwife. Factors such as age, family situation, and financial situation are taken into account in the decision making regarding implementation. Attitude towards job satisfaction and workload is also important.

Participants mentioned that the way a midwife wants to organise care changes during her career. After graduation, midwives are eager to work hard with a high workload, but as they get older, they perceive a lower workload as more pleasant in the long term.

"If you're young, then you just want to dive in. Often you want to work hard, and of course it's nice if you can earn twice as much money in three days compared to another practice where you have to work six days for that." (M6)

Some midwives find that the younger generation of midwives has a different mentality compared to the older generation, which makes the workload more demanding for the younger ones.

For midwives with young families, working in smaller teams is more challenging because relatively more childcare arrangements need to be made. The flexibility of the partner's work and support from the environment also contributes to the possibilities of the midwife.

"We have two colleagues who have young families, really in the process of building a family. What you notice with them is that they prioritise their family above all else. And I understand that too [.], for them it's a complex process. I think it's somewhat inherent to their stage of life." (M4)

How midwives deal with reduced financial income from working in smaller teams often depends on the necessity of the midwife's income. Although the midwife might want to provide MLCC by working in a smaller team, a lower income might be a barrier.

"You can of course also choose a very small practice where you don't work a lot, but then of course you have a very small income. [.] for women of course then you have all the time and attention, but I have been the breadwinner my whole life. So yeah, I had to bring in the financial income." (M9)

Working in smaller teams, results in more on-call shifts per midwife. On the one hand, because of a smaller workload size, the on-call shifts are experienced as calmer and a relief from the workload. Additionally, less preparation time is needed.

"It helps me because I really do know the women. And it takes me less time to look things up or to arrange things, because you know what's going on. You know what's going on with each person, and I don't have to read a whole birth plan before attending a birth, because I already know. So, it really brings a lot of peace to my work." (M7)

Several midwives with experience of providing MLCC by working in smaller teams say that it makes the midwifery profession more sustainable in the long term.

"…so, that's why my opinion is still or has actually now become even stronger, that I think the answer to retaining in the profession is working in smaller teams with quieter shifts." (M1)

On the other hand, other midwives indicate that being more available increases the workload. One midwife who has not transitioned to working in smaller teams believes that being more woman-centred by providing MLCC leads to more premature turnovers of midwives. Furthermore, the anticipated benefits for midwives of working in smaller teams do not always materialise as expected.

"I had actually hoped that experiencing quieter shifts would offset the sacrifice of being more available. And I find that a bit disappointing." (M4)

Nevertheless, the participants agree that more time and attention for the women increases job satisfaction.

"I do notice, getting to know the ladies better, does bring a lot more job satisfaction." (M7)

"…it certainly had an impact on job satisfaction, because it was just less busy and you simply had more time to really stay with a birth." (M5)

Despite the quieter shifts, the question remains, as in larger practices, whether 24-hour shifts are feasible in terms of providing good care.

> “You know, with the 24-hour shifts, yeah, actually, that’s not really modern anymore. You know, because you also have to consider, you can’t provide good care continuously for 24 hours, you just become less alert." (M5)

Several midwives mention that the on-call duties when working in smaller teams represent a different type of availability, allowing for more freedom.

> "Yes, in my opinion, your job satisfaction increases; maybe you work more often, but you sleep more. [.] and your days are just calmer. […] have fewer days that are really completely free, but your days just look a lot calmer." (M1)

Finally, the personal vision and mentality of both the midwife and the midwifery practice contribute to the willingness to implement working in smaller teams. Midwives who work in smaller teams describe themselves and the practice as experimental, innovative, and creative.

> "You can always reverse things or re-evaluate them for a moment, and not be too rigid in such a PDCA cycle [Plan-Do-Check-Act quality improvement model] that is common nowadays, but also a bit just go with the flow. […] Because then you do it more from your heart and less from the paperwork, that’s how it should be." (M5)

According to several midwives the most important thing is: being willing to try. The formation of this vision and mentality of midwives is greatly influenced by the environment, including the education of midwives and the current society. Society’s standards regarding division of tasks among men and women play a role in the way midwives organise their care, as most midwives are female.

> "I mean, if we start with the fact that most women work part-time and men continue to work full-time, well, the education can’t do anything about that. That’s a societal thing. It’s something that still prevails, it’s still a belief. We as women are supposed to be at home and the man continues working, so that’s already a thing, if that was different, maybe fewer women would quit. It’s still so ingrained in our culture that’s how it’s supposed to be." (M8)

3.5. *Key theme: inner conflict*

Working in a smaller team means fewer midwives in a team and a smaller workload per midwife when on-call than was previously the case in that practice. The shared opinion among the participants is that working in smaller teams results in a better woman-midwife relationship, resulting in better care. On the other hand, all participants are aware that working in smaller teams sometimes has an unwanted impact on their personal lives, due to an increase in on-call shifts. Furthermore, implementation is hindered by the structure of maternity care on financial and organisational levels. This makes that community midwives experience an inner conflict between wanting the best care for the woman and investing personal time and effort without financial compensation, questioning how much better care is worth.

> "We know exactly what the best care is, and we just don’t do it [.] There are really colleagues who want this, but it’s often, yes, the fear or, how do you do this, how do you organise this?" (M3)

> " Where is the boundary in meeting the women’s needs [.] It’s sometimes also quite painful, because you don’t always provide care as you might ideally want to, because we’re dealing with so many things, and we just hope that we at least [community midwives ourselves] hold our ground and do what’s best for the woman, but you also know that sometimes it could still be even better." (M8)

4. Discussion

Dutch community midwives experience an inner conflict concerning the implementation of working in smaller teams. A major motivation for transitioning to smaller teams is to provide the best possible care for women. However, the current structure of maternity care at a financial and organisational level is a barrier to working in smaller teams. The personal interests, vision, and private lives of community midwives play a crucial role in how they address both these motivators and barriers.

4.1. *Dilemma*

The finding that community midwives experience an inner conflict about working in smaller teams aligns with earlier research on the implementation of MLCC in midwifery community practices [23]: while the majority of midwives held a positive attitude towards MLCC, they hesitated to implement the model in their own practice. As an explanation for this conflicting attitude, it was suggested that, on the one hand, MLCC by midwives enhances physiology of pregnancy and labour [5] and midwives’ autonomy [24]; on the other hand, limited understanding of the designs of MLCC models and previous negative experiences with attempts to implement an MLCC model act as barriers [23]. A cross-sectional study demonstrated that 50 % of midwives who were not currently working in an MLCC model were willing to do so in the future [8]. They did not identify predictive factors for the willingness to work in smaller teams. It was considered likely that, for some midwives, experience with the model would positively influence their willingness to work in an MLCC model, while for others, it might not.

Our research reveals similar themes among both caseload midwives and those in smaller teams compared to what was found among Australian midwives working caseload. For these midwives [25], as well as for Danish midwives who transitioned to working in an MLCC model [20], it is shown that the benefits outweigh the drawbacks. In contrast, our research indicates that for some community midwives who work in smaller teams, the benefits do not necessarily outweigh the disadvantages. They experience that the practical advantages are less than expected but persist in working in smaller teams nonetheless. This might play a role in the sustainability of working in smaller teams on the long term. For midwives, the dilemma revolves around the choice between allocating more time to providing optimal care for the women or prioritising personal time and fair financial compensation. This raises questions about the value of better care and how much the benefit for the woman should cost the caregiver. The inner conflict experienced by community midwives regarding working in smaller teams is, therefore, not only a practical issue but an ethical dilemma as well. They must weigh the welfare of both themselves and the women they care for, recognizing that prioritizing one may come at the expense of the other.

While in our study opinions vary regarding the workload in MLCC and the sustainability of working in smaller teams on the long-term, several studies suggest fewer burnouts among midwives working in MLCC models [13,26,27]. A Dutch study exploring the rate of and reasons why midwives leave their profession, showed that nearly one third of midwives considered leaving [17]. A survey in the United Kingdom [28] among 2000 midwives revealed that as many as 66 % had considered leaving their profession. It is argued that implementing MLCC and emphasizing job satisfaction among midwives could lead to an increase in midwife retention [17]. This is important to consider, particularly amidst the ongoing global staffing crisis in maternity care: the global shortage of midwives has reached 900,000 [29]. Another Dutch study suggests that a workload size of 106 women per midwife is too high and contributes to stress and burnout [30]. Hence, working with a smaller workload size, like with working in smaller teams, appears to be a more sustainable approach of work. To ensure the success of this MLCC model, it is important to lower the workload size for midwives.

4.2. Women's autonomy and needs

In some practices, the autonomy of the pregnant woman plays a significant role in whether or not working in smaller teams is offered. Promoting women's autonomy is crucial in midwifery, and autonomy stands as one of the ethical pillars to which midwifery adheres [31]. However, it can be questioned to what extent women can make an informed choice when they have no prior experience with this model of care. Additionally, emphasizing women's autonomy too much may conflict with the other ethical pillars: beneficence and non-maleficence. There are variations in how different midwifery practices offer care, with the majority being larger practices. However, pregnant women are often not informed about these practice variations and the potential benefits associated with certain forms of care. One might question the extent to which a woman can fully understand the implications of her choice about how many midwives she wishes to see during her pregnancy and birth, particularly when she is unaware that opting for MLCC by seeing fewer midwives significantly contributes to better health outcomes.

Other practices base the decision of whether or not to offer working in smaller teams on the needs of women. A realist evaluation [7] showed midwives' experiences of a positive impact of MLCC on the outcomes of vulnerable women. The expected positive impact of personalised care for vulnerable women is further supported by an Australian qualitative study involving women referred to social work services [32] and a Dutch cross-sectional study [33] among community midwives working with vulnerable women. However, it is questioned to what extent midwives are capable of identifying the vulnerability of women [33,34]. Restricting the offer of MLCC solely to those who are considered vulnerable, and therefore, excluding parts of the population to this better care, may raise concerns regarding the bioethical principle of justice [31]. However, justice encompasses both equality and equity: while this disparity conflicts with the promotion of equality, it can be argued that tailoring care to meet individual needs aligns with the concept of equity, ultimately leading to comparable health outcomes across the entire pregnant population [31]. The ethical question is if it is justified to offer MLCC on needs of the woman, considering that MLCC leads to better outcomes for all women and children [5]. Therefore, it is worth considering whether MLCC should be the default option. This would ensure that the majority of women receive this type of care, while still allowing them to choose their midwifery practice and also have the flexibility to attend appointments at times that suit them, rather than being restricted to appointments with their designated midwife.

4.3. Strengths and limitations

There are several strengths regarding this qualitative research. First, this is the first study in the Netherlands that provides insight into the experiences of community midwives regarding working in smaller teams. Second, a broad range of perspectives was sought. An iterative approach was taken to engage midwives with diverse characteristics to create a heterogeneous sample. The fact that various experiences and perspectives emerged from the interviews indicates that participants were open to the interviewer, and heterogeneity was reflected. However, there are limitations to this research. One might assume that since this study was conducted within the specific setting of the Dutch maternity care system, the results might not necessarily apply to other countries and healthcare systems. However, the phenomenon of 'working in smaller teams' is not exclusive to the Netherlands, and most themes found in this study align with findings from other studies conducted elsewhere. A second limitation might be the absence of a fixed definition of 'working in smaller teams'. The multifaceted conceptual definition may potentially reduce the internal validity of this research. On the other hand, the participation of midwives from various practice sizes and different parts of the country broadens the external validity.

4.4. Recommendations

First, the midwifery profession should have more discussions about which approach to working in smaller teams most improves the quality of care. Concrete agreements can emerge from these discussions regarding the different forms and the ideal setup of working in smaller teams and the maximum number of midwives women should meet. Second, lowering the workload size of midwives is crucial to sustain working in smaller teams in the long term. To effect this policy change, professional groups and client organisations should bring the health benefits of working in smaller teams to the attention of policymakers and health insurance companies. Finally, discussions within the profession are needed about finding the right balance between what is best for the woman as well as the midwife.

5. Conclusion

This study showed that community midwives experience an inner conflict. Working in smaller teams to offer the best care to the woman is an important motivation for them. However, the ideal way of providing this best care varies per midwife and per midwifery practice. Ideally for a midwife, a practice consists of multiple small teams. The structure of maternity care, both financially and organisationally, is a barrier to working in smaller teams. How the community midwife deals with these motivators and barriers is influenced by her personal interests, vision, and personal life. It is recommended to stimulate discussions within the profession about the practical and ideological aspects of working in smaller teams. Additionally, improving the national midwifery registration and bringing attention to the importance of working in smaller teams to policymakers is advised. The recommendations aim to reduce the inner conflict of community midwives, thereby promoting the implementation of working in smaller teams and MLCC for every pregnant woman.

Funding

The COntinuity of MIdwifery Care (COMIC) project is funded by ZonMw and is carried out by the Midwifery Research Network Netherlands (MRNN). The funding source did not have any involvement in the study design, data collection, analysis, or interpretation.

Ethical statement

The Medical Ethics Committee (METC) of the University Medical Center (VUmc) declared that no formal ethical approval was required for this study in the Netherlands (reference number 2022/382). Respondents provided verbal and written consent to participate in the research and could withdraw at any time. The interviews were anonymized and then stored in a secure environment for 15 years. Only the researchers of the COMIC team have access to this data.

CRediT authorship contribution statement

Marcelle van Wijngaarden: Conceptualization, Methodology, Data curation, Writing – original draft, Visualization. **Hinke Blonk:** Conceptualization, Methodology, Data curation, Writing – original draft. **Renate Simmelink:** Conceptualization, Methodology, Investigation, Data curation, Writing – review & editing, Supervision. **Nadine van der Lee:** Writing – review & editing. **Hanneke Harmsenvan der Vliet-Torij:** writing – review & editing. **Marianne Nieuwenhuijze:** writing – review & editing. **Ank de Jonge:** Conceptualization, Methodology, Writing – review & editing, Supervision. **Corine Verhoeven:** writing – review & editing, supervision

Declaration of Competing Interest

None.

Acknowledgment

The authors gratefully acknowledge the valuable contributions of the midwives who participated in the interviews.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2024.101663.

References

[1] R. De Vries, M. Nieuwenhuijze, S.E. Buitendijk, What does it take to have a strong and independent profession of midwifery? Lessons from the Netherlands, Midwifery 29 (10) (2013) 1122–1128.
[2] Royal Dutch Organisation of Midwives. Het verloskundig systeem [Midwifery System]. 2013 [cited 31 October 2023]. Available from: ⟨https://www.knov.nl/over-knov/samenwerken/verloskundig-systeem⟩.
[3] Perined. Perined [Internet]. Utrecht. 2022 [cited 20 December 2023]. Available from: ⟨www.peristat.nl⟩.
[4] Dutch Healthcare Authority. Prestatie- en tariefbeschikking verloskunde [Performance and fee determination in Midwifery] - TB/REG-19622-02. 2023; 1–14.
[5] J. Sandall, C. Fernandez Turienzo, D. Devane, H. Soltani, P. Gillespie, S. Gates, et al., Midwife continuity of care models versus other models of care for childbearing women, Cochrane Database Syst. Rev. 2024 (4) (2024).
[6] D.A. Forster, H.L. McLachlan, M.A. Davey, M.A. Biro, T. Farrell, L. Gold, et al., Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: Results from the COSMOS randomised controlled trial, BMC Pregnancy Childbirth 16 (1) (2016) 1–13.
[7] H. Rayment-Jones, S.A. Silverio, J. Harris, A. Harden, J. Sandall, Project 20: Midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how, Midwifery 84 (2020).
[8] M. Newton, K. Dawson, D. Forster, H. McLachlan, Midwives' views of caseload midwifery – comparing the caseload and non-caseload midwives' opinions. A cross-sectional survey of Australian midwives, Women Birth 34 (1) (2021) e47–e56.
[9] C.J. Hollins Martin, J. MacArthur, C.R. Martin, R.J. McInnes, Midwives' views of changing to a Continuity of Midwifery Care (CMC) model in Scotland: a baseline survey, Women Birth 33 (5) (2020) e409–e419.
[10] B. Taylor, F. Cross-Sudworth, L. Goodwin, S. Kenyon, C. MacArthur, Midwives' perspectives of continuity based working in the UK: a cross-sectional survey, Midwifery 75 (2019) 127–137.
[11] C.A. Pace, S. Crowther, A. Lau, Midwife experiences of providing continuity of carer: a qualitative systematic review, Women Birth 35 (3) (2022) e221–e232.
[12] F. Leavy, H. Leggett, Midwives' experiences of working in team continuity of carer models: a qualitative evidence synthesis, Midwifery 112 (2022) 103412.
[13] M.S. Newton, H.L. McLachlan, K.F. Willis, D.A. Forster, Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia, BMC Pregnancy Childbirth 14 (1) (2014) 1–16.
[14] K. Dawson, M. Newton, D. Forster, H. McLachlan, Exploring midwifery students' views and experiences of caseload midwifery: a cross-sectional survey conducted in Victoria, Australia, Midwifery 31 (2) (2015) e7–e15.
[15] S. Hailemeskel, K. Alemu, K. Christensson, E. Tesfahun, H. Lindgren, Health care providers' perceptions and experiences related to Midwife-led continuity of care-a qualitative study, PLoS One 16 (10) (2021) 1–15.
[16] N. Dharni, H. Essex, M.J. Bryant, A. Cronin de Chavez, K. Willan, D. Farrar, et al., The key components of a successful model of midwifery-led continuity of carer, without continuity at birth: findings from a qualitative implementation evaluation, BMC Pregnancy Childbirth [Internet] 21 (1) (2021) 205.
[17] E.I. Feijen-de Jong, N. van der Voort-Pauw, E.G. Nieuwschepen-Ensing, L. Kool, Intentions to leave and actual turnover of community midwives in the Netherlands: a mixed method study exploring the reasons why, Women Birth 35 (6) (2022) e573–e582.
[18] H. Perdok, S. Jans, C. Verhoeven, L. Henneman, T. Wiegers, B.W. Mol, et al., Opinions of maternity care professionals and other stakeholders about integration of maternity care: a qualitative study in the Netherlands, BMC Pregnancy Childbirth 16 (1) (2016) 1–12.
[19] Royal Dutch Organisation of Midwives. The COMIC continues [Internet]. 2023 [cited 11 May 2023]. Available from: ⟨https://www.knov.nl/actueel/nieuws/nieuwsbericht/the-comic-continues⟩.
[20] A.L. Strauss, J.M. Corbin, Basics of Qualitative Research, Sage, Thousand Oaks, California, 1990.
[21] R.J. McInnes, A. Aitken-Arbuckle, S. Lake, C. Hollins Martin, J. MacArthur, Implementing continuity of midwife carer – just a friendly face? A realist evaluation, BMC Health Serv. Res 20 (1) (2020) 304 (Available from:).
[22] J. Fenwick, M. Sidebotham, J. Gamble, D.K. Creedy, The emotional and professional wellbeing of Australian midwives: a comparison between those providing continuity of midwifery care and those not providing continuity, Women Birth 31 (1) (2018) 38–43.
[23] M.C. Edmondson, S.B. Walker, Working in caseload midwifery care: the experience of midwives working in a birth centre in North Queensland, Women Birth 27 (1) (2014) 31–36.
[24] I. Jepsen, E. Mark, E.A. Nøhr, M. Foureur, E.E. Sørensen, A qualitative study of how caseload midwifery is constituted and experienced by Danish midwives, Midwifery 36 (2016) 61–69.
[25] A. Hanley, D. Davis, E. Kurz, Job satisfaction and sustainability of midwives working in caseload models of care: an integrative literature review, Women Birth 35 (4) (2022) e397–e407.
[26] A. Kashani, J.L. Ingberg, I. Hildingsson, Caseload midwifery in a rural Australian setting: a qualitative descriptive study, Eur. J. Midwifery 5 (1) (2021) 1–9.
[27] B. Hunter, J. Fenwick, M. Sidebotham, J. Henley, Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors, Midwifery 79 (2019) 102526.
[28] World Health Organization. New report sounds the alarm on global shortage of 900 000 midwives [Internet]. 2021 [cited 13 December 2023]. Available from: ⟨https://www.who.int/news/item/05-05-2021-new-report-sounds-the-alarm-on-global-shortage-of-900-000-midwives⟩.
[29] D. Cronie, H. Perdok, C. Verhoeven, S. Jans, M. Hermus, R. de Vries, et al., Are midwives in the Netherlands satisfied with their jobs? A systematic examination of satisfaction levels among hospital and primary-care midwives in the Netherlands, BMC Health Serv. Res 19 (1) (2019) 832.
[30] T.L. Beauchamp, J.F. Childress. Principles of Biomedical Ethics, 8th ed., Oxford University Press, New York, 2019.
[31] V. Vasilevski, K. Graham, F. McKay, M. Dunn, M. Wright, E. Radelaar, et al., Barriers and enablers to antenatal care attendance for women referred to social work services in a Victorian regional hospital: a qualitative descriptive study, Women Birth 37 (2) (2024) 443–450.
[32] E. Vlassak, K. Bessems, J. Gubbels, The experiences of midwives in caring for vulnerable pregnant women in the netherlands: a qualitative cross-sectional study, Healthcare 11 (1) (2022) 130.
[33] A.A. Vos, A. Leeman, A.J.M. Waelput, G.J. Bonsel, E.A.P. Steegers, S. Denktaş, Assessment and care for non-medical risk factors in current antenatal health care, Midwifery 31 (10) (2015) 979–985.