"A powerful midwifery vision": Dutch student midwives' educational needs as advocates of physiological childbirth

Suzanne M. Thompson[a,b], Marianne J. Nieuwenhuijze[a], Lisa Kane Low[c], Raymond De Vries[a,b]

[a] *Research Centre for Midwifery Science, Zuyd University, PO Box 1256, 6201 BG Maastricht, The Netherlands*
[b] *CAPHRI, School of Public Health and Primary Care Maastricht, PO Box 616, 6200 MD, Maastricht, The Netherlands*
[c] *School of Nursing and Department of Women's Studies, University of Michigan, 400 North Ingalls Building, Ann Arbor, MI 48109-5482, USA*

Abstract

Background: In order to internalize the midwifery philosophy of care and to learn how to advocate for physiological childbirth, student midwives in the Netherlands need learning experiences that expose them to physiological childbirth practices. Increased hospital births, wide variation in non-urgent referrals and escalating interventions impact on learning opportunities for physiological childbirth.
Midwifery educators need to find ways to support student agency in becoming advocates of physiological childbirth.
Objective: To gather students' opinions of what they need to become advocates of physiological childbirth.
Methods: Focus groups with student midwives (n = 37), examining attitudes regarding what educational programs must do to support physiological childbirth advocacy.
Results: Students reported feelings of personal power when the midwifery philosophy of care is internalized and expressed in practice. Students also identified dilemmas associated with supporting woman-centered care and promoting physiological childbirth. Perceived hierarchy in clinical settings causes difficulties, leading students to practice in accordance with the norms of midwife preceptors. Students are supported in the internalization and realization of the midwifery philosophy of care, including physiological childbirth, if they are exposed to positive examples of care in practice and have opportunities to discuss and reflect on these in the classroom.
Key conclusion: Midwifery education should focus on strategies that include navigating dilemmas in practice and helping students to express the midwifery philosophy of care in communication with other professionals and with women. Preceptors need to be supported in allowing student midwives opportunities to realize the midwifery philosophy of care, also when this differs from preceptor practice.

Keywords: physiological childbirth, student midwives, midwifery, philosophy of care, power, role models

Statement of significance

Problem or issue
Medicalization of childbirth reduces student midwife exposure to physiological childbirth and may affect agency to advocate for physiological childbirth.

What is already known
Lack of exposure to physiological childbirth causes difficulties for students to internalize and work according to the midwifery philosophy of care.

What this paper adds
Internalizing and expressing the midwifery philosophy of care allows students to feel powerful and students need positive role models.

Implications for practice
Preceptors need to be supported in allowing students opportunities to realize a midwifery philosophy of care, also when this differs from preceptor practice.

1. Introduction

In the Netherlands, midwives in primary care are responsible for care provision to healthy women with uncomplicated pregnancies. They refer women to obstetrician-led care (secondary care) when there are complications or an increased risk of complications.[1] Increasingly, midwives are also working in hospitals under the supervision of obstetricians, where they care for the majority of women, including women who have been referred because of complications in pregnancy or birth.[2] The education of midwives in the Netherlands follows a four-year, direct-entry Bachelor of Science programme. Graduation from this allows admittance to the professional register (BIG register). Approximately half of the curriculum is comprised of clinical placements in communities or hospitals throughout the country, where students are supervised by preceptors who are registered midwives.

The midwifery philosophy of care[1,3] advocates physiological childbirth and Dutch midwives in all settings consider a physiological approach to childbirth as fundamental to their role.[4] However, this perspective appears at odds with quantitative studies from the Netherlands that demonstrate increasing numbers of non-urgent referrals to obstetric-led care in the intrapartum period and a wide diversity in referral rates between midwifery practices, varying between 9.7 and 63.7%.[5] There is also wide variation in specific areas of midwifery practice, including large differences in the use of episiotomy between primary care midwives.[6] It is unlikely that the variation in practice is the result of different population characteristics; it is more likely that the observed variation is caused by differences in midwife perceptions of the probability of adverse events in birth[7] and variation in habitual patterns of practice.

At present, the Dutch midwifery system is moving towards an integrated model of care.[8] This model includes an extended remit for midwives to provide care to women defined as low *and* medium risk. While rates of obstetric interventions, e.g. cesarean section, in the Netherlands remain low compared to other industrialized countries,[9] there is concern among midwives and others that an integrated model of care may lead to more interventions,[8] increasing the cost of care and introducing the possibility of harm to the health and well-being of women and their babies.[10,11]

Changes to the maternity care system inevitably impact on the way in which Dutch midwives are educated. Midwifery curricula have been optimized in order to reflect the extended remit of the midwife within an integrated model of care. Evidence suggests that students entering midwifery programmes are motivated to do so from feelings of altruism and the desire to 'support and empower' women and safeguard the birth experience by promoting physiological birth and reducing unnecessary medical interventions.[12] Learning a new profession involves cognitive and affective processes — the acquisition of knowledge and skills and the acceptance of a set of professional values and beliefs.[13] For student midwives, part of professional socialization involves internalizing, or value embodiment, of a set of professional beliefs[14] — the midwifery philosophy of care, including the promotion of physiological childbirth.[14] The opportunity to observe 'hallmark' midwifery behaviour, such as non-intervention in the birth process in the absence of pathology, is significantly associated with student self-efficacy in assuming such behaviours themselves.[15] When asked to describe what constitutes a 'good midwife', Dutch student midwives point to the importance of a physiological approach to birth and the avoidance of unnecessary interventions.[16]
While midwifery education may address the importance of midwifery support for physiological childbirth[17] learning in real-life practice situations is likely to be more relevant to the student midwife than theory-based learning[13] in the classroom. The discrepancy between theory and practical learning (theory-practice gap) is described by Meyer, Argryis and Schön as the difference between loyalty to a set of beliefs (theory) and loyalty to the actual values reflected in professional practice (theory in use). They also note that gaps between theory and practice are linked to decreases in both professional power and the self-esteem of the learner.[18]
Midwives provide effective, safe maternal and perinatal care which promotes health and well-being.[19,20] However, it is important that there is balance between care that is neither 'too much too soon' or 'too little too late'.[21] It is, therefore, imperative to educate midwives to be competent and confident in employing strategies that support physiological childbirth for the women in their care. Midwifery education should develop strategies that encompass both classroom and practical learning and that develop and support self-efficacious behaviour, principally in clinical settings. Successful development of an educational programme that can do this must include the views of learners themselves, in this case, student midwives.

2. Methods

We conducted a qualitative study in the Netherlands between May and October 2017 exploring Dutch student midwives' attitudes and motives with regard to promoting physiological childbirth and what they feel they need from educational programmes in order to effectively fulfil this role.

2.1. Design

We used focus groups to collect data on student midwives' attitudes towards physiological childbirth, asking them to reflect upon discrepancies between midwifery in the classroom and the realities of practice and to describe their strategies for dealing with 'practice-theory gaps'. In addition, we asked them to consider what must be done in order to promote their competencies as practitioners of physiological childbirth.

2.2. Setting and participants

Following permission from the managers of the three midwifery programmes in the Netherlands, we approached fourth year student midwives by e-mail, with written information about our study and an invitation to participate. We conducted five focus groups: two in Maastricht, and one each in in Rotterdam, Groningen and Amsterdam.
The study was reviewed and approved by the Zuyderland Zuyd ethics committee (17-N-27).

2.3. Data collection and analysis

We used the Attitude, Subjective Norms and (self) Efficacy (ASE) model[22] to frame questions for the creation of a semi-structured focus group topic list. The ASE model is a useful theoretical framework for exploring how attitudes, norms, and self-efficacy facilitate or inhibit new behaviour. The topic list (Table 1) was pilot-tested on a group of fourth year student midwives to confirm both clarity and open-endedness of the questions. The first author, an experienced interviewer, conducted the focus groups, while the second author or another researcher was present to observe and make field notes.

Each focus group lasted between 65 and 90 min. The discussions were audio-recorded and transcribed verbatim. Transcripts were checked against audio recordings for accuracy. Participants were assigned a pseudonym in order to preserve confidentiality. Informal member checks, in which input was summarized and checked with participants, were conducted at the close of each focus group.

Data collection and analysis were concurrent, allowing for reflection on the viewpoints of the participants. Data were analysed using thematic analysis[23] supported by NVivo. Transcripts were read and re-read in order to facilitate deep engagement with the data. Following this, the first author attached codes to small segments of the transcripts. Codes were then reviewed by the second author. Themes emerging from the data were identified and these were checked to determine relevance in relation to the data. This was done visually, utilizing thematic networks.[24] Candidate themes were refined and reviewed, going back to the data to establish coherent patterns and these were reviewed again by the second author in order to ensure confirmability of findings. Quotes illustrating the themes were identified and given a pseudonym.

Table 1. Topic list

- What does the term 'physiological childbirth' mean to you?
- A midwifery role that is described nationally and internationally is the support and promotion of physiological childbirth: when you think about this, how do you feel that midwifery education prepares you for this?
- Do you see examples of physiological birth practices around you? What examples are these?
- Do you feel that the theory aspects of midwifery training offer enough focus on knowledge and skills for promoting physiological childbirth?
- Do you make use of scientific evidence to help you support and promote physiological birth? Is it readily available for you and do you feel able to use it?
- How about clinical placements? Which role models are there and what do these role models do to let you see how physiological childbirth can be supported and promoted?
- When you are attached to clinical settings (either community or hospital) how do you promote and support physiological childbirth?
- Can you describe situations where you wanted to do more to promote physiological childbirth but were unable to do so?
- Can you describe factors that might encourage you to promote physiological childbirth whilst you are in clinical settings?
- What can be learning strategies that prepare you for your role in physiological childbirth?

3. Findings

E-mails were sent to 160 student midwives in their fourth year of academic study. Thirty-seven student midwives participated in this study (response rate 23%). All were in their fourth year of academic study. Participants were recruited from each of the three midwifery programmes in the Netherlands. While each programme determines its own study route, the end-competencies are identical, and fourth year students will have had similar educational experiences, in both education in the classroom and in practice. All participants were female, aged between 20 and 25.

Three major themes emerged from our data: 'Personal power', 'Gaining a voice', and 'Learning by example'.

3.1. Personal power

Students in our study indicated that being able to internalize the midwifery philosophy of care that encompassed a physiological approach to childbirth, and develop a personal approach to realizing this, was associated with feelings of growing personal power as a practitioner of physiological childbirth. This process occurred as a result of experiences during midwifery education. Being allowed the learning opportunity to develop a personal approach and provide midwifery care in accordance with the midwifery philosophy of care was considered important in developing as a midwife.
. . . if I really want to stand up for something, then I need to be able to do it for myself . . . (Jeanne).

The midwifery philosophy of care was apparent in the way students discussed their approaches to the profession of midwifery. While they found it challenging to define physiological childbirth, reverting to "absence" rather than "presence" terms such as 'low risk' and 'absence of complications', they described scenarios in which they were able to observe the woman and the progress of labour, as an advocate of physiological childbirth,
. . . (keeping your) eyes on the woman and not on the things around her. Other things: sitting quietly, observing her . . . the focus on her. Where you don't do anything, that you 'guard' that it (the birth) is physiological and stays so. That you keep an eye on things. But that you don't have to do anything . . . (Anouska).

Student midwives described scenarios in which unnecessary intervention in childbirth should be avoided. In addition to this, working in ways that allowed time to be patient and be 'with women' were seen as essential.

Woman-centred approaches to midwifery care were detailed as central to the midwifery philosophy of care. Student midwives described the importance of supporting the woman to find her own power to give birth. This related to a view in which the student midwives felt that they were able to empower women to have trust in the physiology of childbirth. They considered the fostering of women's trust in their own bodies to be an important part engendering the woman's personal power. Learning how to do this was seen as important, because they were convinced by their experiences, particularly during clinical placements, that women who experience physiological childbirth are more satisfied.
*I think, for the woman that it gives (*her*) more trust in herself and that she looks back on it (*the birth*) with more satisfaction if it's physiological (Debbie).*

Students pointed out that another facet of expediting the woman's power to give birth was in careful use of the language around birth. Terms such as 'doing the delivery' were avoided by some students. Wendy told us,
I never say, 'I did a nice delivery'. I always say things like 'I was present at a beautiful birth' or something like that, you know? (Wendy).

Several of our respondents mentioned the value of shared decision-making for empowering women. Students talked about how the development of a trusting relationship with the woman facilitates personal power for the woman in making choices in childbirth. However, while student midwives felt that the wishes and needs of women should be paramount in physiological childbirth, they experienced tension between advocating the midwifery philosophy of care and their understanding of what woman-centred care constitutes. This was articulated in concerns about *imposing* midwifery philosophy on the women in their care. Student midwives expressed the desire to maintain neutrality and balance women's choices against evidence-based actions that promote physiological childbirth. Vera explained,
I try to find a balance between her choice to give birth in bed and motivating her to get off the bed . . . I find this a difficult consideration (Vera).

Student midwives described resources they found helpful in increasing their personal agency as advocates for physiological childbirth. One such resource was using evidence-based practice (EBP) to help develop a critical attitude towards their own, and other professionals', practice. The student midwives in our study described EBP as a resource in which they learned to formulate their own thoughts and questions about practices that they observe,
. . . without being judgemental, I think it's a good feature to ensure that your own physiological approach - and that of your colleagues - is preserved (Jeannette).

Some students acknowledged that the transition from thought to action can be difficult, notably when their perspective on care differed from that of another professional. While EBP was cited as a useful resource to formulate thoughts or ask questions, it seemed that student midwives saw few examples of preceptors or other professionals using EBP to frame discussions about differing approaches to maternity care. This is also visible in the development of evidence-based practice protocols and directives, where the limited use of both evidence and midwifery involvement may have consequences for the shaping of optimal midwifery care. Danielle gave an example about a lack of discussion or midwifery involvement in the shaping of regional protocols and directives,
. . . and then it's, like, 'we can't take everyone's opinion on board'. So, the protocol for a whole region is determined by five people
. . . (Danielle).

3.2. 'Gaining a voice'

Student midwives reported various resources that increased their personal power but noted that using these in clinical settings was challenging. Established hierarchy and feelings of dependency on the preceptor are factors that led to students feeling that they lack the ability to speak out in clinical settings.
Students described the power dynamics of the clinical placement, in terms of a hierarchy where they were on the lowest rung. In the hospital setting being lower in the hierarchy often translated to students feeling that their voices were unheard,
Nine times out of ten, I swallow my words and think 'who am I to say anything?' (Saskia).

Students also noted that in the hospital their own midwifery experience was not taken into account by other professionals, an experience they described as demoralizing,
. . . There's this high-handedness, the way (they) look down at you . . . no-one sees your experience (Milou).

However, perceived hierarchy was not limited to hospital settings; students also experienced community midwifery practices as hierarchical. In midwifery practices students felt that they had to adhere to the norms and values of the practice as determined by the midwives in 'their' practice. This led to students having to adapt or 'fit in' to the clinical settings to which they were assigned during midwifery training.

This adaptation was primarily driven by feelings of dependency on the preceptor, who is not only a mentor, but also the one who will evaluate the student's work during placements.

Mia described this as follows: *You're in a dependent position; you need something from them (the preceptor). And that's a discrepancy that, um, I think . . . holds you back . . . from challenging their practice or from standing up for your own (approach to midwifery) philosophy (Mia).*

Student midwives indicated that they felt that it was expected of them to assume similar ways of practising to that of their preceptor. This presented challenges, especially when students felt that their personal realization of the midwifery philosophy of care was different from that of the preceptor.
As a student, you can have a physiological approach, but you have to practice according to their (the preceptors') *rules, . . . then you intervene and do vaginal exams every two hours (Joyce).*

Having to adapt created conflict for the students in our study. Midwifery programmes expect students to internalize the midwifery philosophy of care and realize this in practice settings during their education. Students set measurable learning goals in order to demonstrate that they are able to do this. However, the reality that students described offers little or no opportunity to practice differently from their preceptors, leading to students setting their personal approach to practice aside to do what is asked of them. An inability to internalize a philosophy for midwifery care in line with (inter) national definitions and to realize this in practice has significant consequences, especially with regard to concerns about increasing medicalization of childbirth.

However, there *were* situations in which students felt they could develop their own voices and advocate for physiological childbirth practices. The opportunity to observe, and be involved in, genuine collaborative ways of working between community midwives and obstetricians was viewed as positive. Genuine collaboration fostered an environment in which questions and discussions were encouraged in order to facilitate maternity care based on best practices from various professional backgrounds. The establishment of collaborative relationships with other care providers was viewed as facilitative, with students being more willing to discuss or to challenge practice. This often depended on earlier positive experiences, or hearing positive things about a particular care provider,
For me, it depends a lot on who (i.e., care provider) is opposite me. If it's someone you know – who I've seen more often or have spoken to a couple of times. Or, I've heard good stories about them – then I'm much more willing to say what I think and that I don't agree with them (Alexis).

While positive experiences with other care providers was associated with readiness to challenge practice or discuss differences, the unspoken implication is that, where experiences are less positive, student midwives are less willing to get into discussions with other care providers. Interestingly, one student noted the importance of building collaborative relationships, to ensure that other professionals develop overall confidence in the physiological midwifery approach,

When you work with them regularly and you can build trust . . . once you've achieved trust they'll be more likely, yes, it sounds a bit strange, but they'll be quicker in having confidence in your approach. I noticed this in a hospital where I'd had an earlier placement, it was, like, 'oh, there's Sophie, we know her', you know?' . . . it feels much better, you can be open with one another, work together (Sophie).

3.3. 'Learning by example'

Students told us that in order to advocate for physiological childbirth, it is essential to have opportunities to observe physiological care practices and see how midwives advocate for physiological childbirth in their interactions with women or with other professionals. Student midwives also looked to their peers from whom they could learn.

3.3.1. Learning from midwives

The student midwives in our study discussed the importance of being able to learn by example, in both clinical placements and in the classroom. Learning during clinical placements was paramount with students. We heard about both negative and positive examples for learning.

Student midwives highlighted the diversity of placements, principally in the community, observing that while some midwifery practices espoused a physiological approach to maternity care, other practices were less physiology minded. This exposure to differing approaches contributed to the development of the students' personal realization of the midwifery philosophy of care, noting which practices and professional behaviours to incorporate and which not. The diversity experienced by students also raised concerns, particularly if students felt that they were insufficiently exposed to certain practices or behaviours, such as water birth or birth in non-supine positions.

Some students expressed feelings of doubt about implementing aspects of midwifery care that they had not had the opportunity to experiment with during clinical placements. Theory alone seems inadequate if it is not reinforced during clinical placements,

. . . we had, I think, a lesson about birthing positions and then . . . if you don't see it (non-supine birthing positions) during placements then it's not something that you feel proficient, and then you try it less quickly (Marie-Louise).

Some students reported experiencing freedom to experiment during placements, although how much freedom to practice the student was allowed seemed to be related to preceptor experience. Students described experienced midwives being willing to allow students freedom to experiment, in this example with a birthing stool. Less experienced colleagues appeared uncomfortable with this practice and students felt under surveillance. Anneliese told us,

There was a huge difference the hospital midwife who said 'do it, do anything, let me know if you need me. Or the resident who's breathing down your neck. It's difficult to know your place. The midwife says get (the woman) pushing on the birthing stool and the resident is, like, oh, no! No! (Anneliese).

Exposure to physiological birth practices is one aspect of developing core midwifery competencies; attitudinal development is another important aspect. Students cited the attitude that the midwife preceptor has to promoting and supporting physiological childbirth as important for their learning. One student told us that she experienced that,
If the midwives are also physiological, that they give you that (physiological attitude) more than if they are _ different _ or quickly afraid birth deviating from normal they take you with them (Carine).

3.3.2. Learning from peers

Student midwives also discussed the examples they had heard during the classroom portion of their midwifery education, mentioning the value of case histories as a way of learning about clinical situations. Notably, peer-to-peer reflection was mentioned by students as giving them the space to discuss, reflect upon, internalize and develop strategies to incorporate midwifery philosophy of care into their practice. This is a structured activity, in which peer students, usually in groups of 8–12 and facilitated by a lecturer/coach, discuss aspects of learning that the student has experienced during clinical placements. Peer-to-peer reflection is facilitated during clinical placements via a digital platform and as a classroom-based activity. Reflective learning is central to this process. While some students found that there was too much focus on reflection, others saw the value of a structured, reflective activity in which to learn about their own – and others – approaches to promoting and supporting physiological childbirth, *I didn't think I'd get so much from it (peer-to-peer reflection), we used to laugh a bit about it, but, for me, it was one of the most important parts of my education. Part of it (peer-to-peer reflection) is about asking critical questions without judgement and I think this helps in promoting your own _ and your colleagues _ physiological approach (Rachel).*

Peer-to-peer reflection was seen as a learning activity in which students could effectively explore some of the gaps that exist between midwifery theory and practice and an activity that allowed exploration of the diverse approaches to midwifery care. Student midwives said that in these sessions learning by example was also important. Some of the examples stemmed from practice situations that they or their peers had experienced. However, students were also inspired by the expression of the midwifery philosophy of the facilitating lecturer and the way in which this was used as part of a teachable moment.
We had a lecturer, with a clear and powerful physiological childbirth philosophy. When we discussed cases, she asked critical questions and we discussed cases in detail and what we could do differently next time (Vera).

The students in our study mentioned how the timing of peer-to- peer reflection affected its value. Peer-to-peer reflection in the first two years of education helped them to develop their role as active learners and to work on personal development as individuals. On the other hand, most students viewed peer-to-peer reflection as best meeting their needs as burgeoning professionals during the final two years of midwifery education. In the third and fourth year, where the focus is on clinical placements, students considered peer-to-peer reflection as an important activity in which to explore and reflect upon the way in which they internalized and worked with the midwifery philosophy and how this subsequently contributed to their professional development. In addition, it offered opportunities to learn from their peers who may have had other experiences, and to assimilate new insights into their personal realization of the midwifery philosophy of care in practice.

4. Discussion

This qualitative study offers insights into how student midwives in the Netherlands learn to appreciate and to advocate for physiological childbirth. In order to do this, students internalize[13,14] the midwifery philosophy of care in which the woman is central, supported by strategies such as shared decision-making and evidence-based practice. An internalized midwifery philosophy and the opportunity to realize this in practice gives the student a sense of personal power, which, in turn, is used by the student to mitigate some of the challenges faced by student midwives during midwifery practice. The most effective learning students experience is when they are surrounded with positive examples from which to learn.
The student midwives who participated in our study equated an internalized midwifery philosophy with feelings of personal power. Halldorsdottir and Karlsdottir[25] in their theory of the 'good midwife' refer to the professional wisdom of the midwife, which is developed through an interplay of both theory and practical experience. In exploring the concept of the 'good midwife' in the Dutch setting,[16] student midwives discussed a 'midwifery vision', or midwifery philosophy of care, as an aspect of professional wisdom. To develop this, student midwives need to acquire both knowledge and skills and need to internalize the values and norms of the profession.[13,14,26] We also found that student midwives experienced conflict between the midwifery philosophy of care and their interpretation of woman-centred care, with students being cautious about advocating physiological approaches to childbirth in an effort to be as neutral as possible when offering information to women. The conflict and dilemmas experienced by these students has been noted elsewhere in the literature[27,28] and student midwives need support in finding ways to deal with this during midwifery education and in practice.[27]

The word power often has negative connotations, implying the exercise of control by one group with power over a less powerful group.[29] However, power, in the context described here is better understood in the context of the different expressions of power as described by VeneKlasen and Miller.[30] They distinguish four types of power: 'power with', 'power to', 'power within', and 'power over'. On the one hand, the students in our study describe some of their relationships with preceptors in terms 'power over' — powerlessness and feelings of dependency. This power imbalance is not uncommon in medical settings, having been described elsewhere in the literature.[31,32] However, the student midwives in our study postulate other expressions of power. Building on 'power within' (the potential power of the individual) and 'power with' (the collective voice), students talked about 'power to' the individual's ability to shape their own world. For student midwives this implies that the creation of a professional identity begins by internalizing and realizing the midwifery philosophy (power within) that guides the individual's practice as a midwife.

Personal power for student midwives also relates to 'power with'. In this expression, power with has to do with working collaboratively in order to build bridges or create equitable relations. Students offered examples of situations in which they learned by observing or directly participating in the creation of genuine collaborative ways of working with other professionals involved in midwifery care. In the last few years there has been increasing focus on creating collaborative ways of working between professionals involved in providing maternity care.[33] It appears that being able to work collaboratively with other care providers is satisfying for midwives.[34] Helmond et al.[35] note that one of the most important pre-requisites necessary for good collaboration between professionals is trust. The students in this study confirm this. They found that when they were able to build trusting relationships, good communication with other professionals followed, facilitating their agency in advocating for physiological approaches to childbirth through discussion and communication with other actors in maternity care.

The perception of an established hierarchy within midwifery is not a new phenomenon.[36] This hierarchy results in the imitation of midwifery preceptor behaviour by student midwives and the inability of student midwives to challenge practice by senior midwives[37] who are responsible for assessing students' progress during placements. The students in our study corroborated these findings. Relationships with preceptors can either hinder or facilitate learning.[38] An encouraging, approachable preceptor can be influential in building student midwife confidence to advocate for physiological childbirth and, importantly, the agency to implement care processes that support this.

The students in our study report gaining benefits for their learning from structured reflective practice with their peers, facilitated by midwifery lecturers who are cognisant of the importance of a physiological approach to childbirth and are familiar with practice settings. Schön[39] describes reflection as an important learning strategy that allows professionals to become aware of their implicit knowledge and able to 'think on their feet'.

Reflection, as a means to enhance learning, has been in wide use in midwifery since the 1990s, although the majority of reflective models stem from nursing, rather than midwifery practice. Collington and Hunt point out that well-structured reflective discussions may encourage student midwives to develop the critical decision-making skills necessary for autonomous practice.[40] Structured reflection can also support students in navigating some of the conflicts that may arise between realizing a personal expression of the midwifery philosophy in practice, the approach of other professionals to childbirth, and the wishes and needs of women. The students in our study confirmed this viewpoint, highlighting the value of structured reflection as a means of exploring approaches to physiological childbirth, supporting them in developing their own midwifery vision, and in navigating some of the dilemmas that arise in practice.

The strengths of this study include the choice of focus groups as an appropriate methodology in order to gain a wide variety of views and rich descriptions from student midwives throughout the Netherlands. Data collection and analysis occurred concurrently, and we paid attention to the auditability of our findings. Reflective notes were made by the first author and all key decisions during data collection and analysis were audited by the second author. It is, as far as we are aware, the first study to examine student midwives' educational needs in order to effectively advocate for physiological childbirth. A limitation of this study is the self-selection of the students who participated. It may be that these students felt an affinity with the subject matter, potentially making them less representative of the student midwife population as a whole. Our aim was to ensure a broad representation of students, and we did include students from each midwifery programme in the Netherlands. Another was the choice to focus solely on the views of student midwives. Midwife preceptors are valuable stakeholders and may have views on how student midwives could develop as practitioners of physiological childbirth. This is worthy of further study but was not within the scope of this paper.

4.1. Implications for midwifery education

This study contributes new insights into what student midwives require of their educational programmes in order to become self-efficacious advocates of physiological childbirth. Our findings have implications for midwifery education in the Netherlands. While midwifery programmes focus on providing theoretical that supports student midwives in internalizing the midwifery philosophy of care, educators must pay attention to helping students to realize this in practice. This includes teaching students to effectively communicate their philosophy and the advantages that physiological birth may have, in interactions with other maternity care professionals and with women and their families. As the students in our study make clear: all too often, discussion and communication of midwifery philosophy is dependent on external factors. Education should be focused on increasing student agency to discuss, debate and challenge aspects of care where there is evidence that supports physiological childbirth. In addition to this, current education about shared decision-making should place greater emphasis on helping students to navigate the dilemma between advocating the midwifery philosophy of care and the wishes and needs of women and communicating to women the advantages that a physiological approach to childbirth may have.

The role played by the midwife preceptor is essential to student midwife learning, and it is especially important that students have exposure to physiological childbirth practices. Midwifery programmes have the responsibility to ensure that there are clinical settings that are able to facilitate these learning experiences. Dutch midwifery programmes currently offer post-graduate courses intended to help preceptors develop clinical teaching and precepting skills. These focus on the development of didactic skills and the use of feedback and reflection for learning. However, there should be a greater emphasis on ensuring that more midwives are aware of the importance of exposing students to physiological childbirth practices. On-going educational input for midwives to support them in increasing their own self-efficacy in employing strategies that promote physiological birth particular may, in turn, increase student midwife exposure to these practices. Additionally, midwife preceptors should be supported in tolerating discrepancies between their own and a student's approach to physiological childbirth, allowing student midwives freedom to realize and work with the midwifery philosophy of care.

Our findings, together with evidence from other settings, underscore the importance of midwifery role models for effective student midwife learning and for the internalization and expression of the midwifery philosophy of care. Further research in the Dutch context should focus on the role that midwives must assume in modelling exemplary midwifery behaviours. There is a role for Dutch midwifery programmes to support and develop preceptorship competencies in fulfilling this role.

Ethics approval and consent to participate

The study was approved in February 2017 by the ethics committee, Zuyderland Zuyd (17-N-27). Written informed consent was obtained from all participants.

Consent for publication

Written consent for publication was obtained from all participants.

CRediT authorship contribution statement

Methodology, Formal analysis. Lisa Kane Low: Conceptualization, Supervision, Writing - review & editing. Raymond De Vries: Conceptualization, Supervision, Writing - review & editing, Project administration.

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