Midwives keeping Women at the Centre of Care 2015

Eileen Hutton,
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Dear colleagues

It is my great pleasure to speak to you at the completion of a five-year term as Professor of Midwifery Science at VU University. During my tenure in this esteemed position I have had the opportunity to discuss ideas and work with colleagues from many research and practice specialties; to work with other research mentors in supervising students; to interface with members of professional organisations; as well as having the great satisfaction of advising PhD students. Four of the PhD students under my direct supervision have completed their studies and successfully defended their thesis within the last 14 months; 3 students are still in progress – all are making a contribution to the evidence that underpins the practice of the midwifery profession.

The Department of Midwifery Science in the EMGO Institute at VUmc has established itself and has a very successful and productive academic program of research. This rigorous research department has contributed to the knowledge base that will improve outcomes for women and newborns in the Netherlands and around the world. The DELIVER study alone has contributed more than 50 papers to inform best care for women and infants. The Midwifery Science department has grown from three senior researchers and three PhD students in 2010 to one associate professor, four senior researchers and 14 PhD students – with 5 who successfully defended their thesis in the last year. The work of the department of Midwifery Science at VUmc is now well established and will most certainly continue.

My Midwifery Professorship has also opened many doors to me personally and led to collaboration – with midwives, obstetricians, with other researchers and with the professional midwifery association. These partnerships have been interesting and productive and have resulted in opportunities for researching and publishing together, mentoring and knowledge translation.

SOME CONTRIBUTIONS OF MIDWIFERY SCIENCE

DELIVER Study[1]

The DELIVER Study has been a remarkable success. It is rare for an individual study to result in such a quantity of new knowledge as was and continues to be the case in the DELIVER study. We have heard today from several of our Midwifery Science PhD graduates as they provided practice implications of their research. The DELIVER Study is significant in its depth and breath of exploration and in the importance of its findings. Studies have provided very specific direction for example in how testing for chlamydia in the Netherlands could be improved; about gaps in knowledge of midwives with regards to infectious disease; about how counselling of couples on prenatal screening and diagnostic tests can be improved; about what midwives feel about working in the future; and about what women think could be different about their care.

Findings from DELIVER have informed the way midwives provide prenatal and infection screening information, and made recommendations for improvements. Our research has considered the specific needs of Muslim women in terms of prenatal screening and reported that women want accurate and detailed information about anomalies that can be detected on tests. Muslim women informed us that making a decision can take time and that they wanted the opportunity to take time, use their own resources and do their own research. They recommended that midwives should respect every woman. We have studied barriers to care among immigrant women. These findings provide explicit direction to midwives and to midwifery students to improve care. Other research from our department identified that midwives are not adequately screening for infectious diseases and recommends that midwives know risk factors associated with Chlamydia infection in order to adequately plan screening for women at increased risk. We found that midwives and pregnant women, as well the partners of pregnant women, showed positive attitudes towards universal testing for chlamydia. In terms of NTD prevention, we report that in the DELIVER study 2009-10 only 56% of women use of folic acid for prevention of neural tube defects, despite a government goal that 70% of pregnant women would be taking folic acid supplements by 2010. At this moment, there is not national plan for pre-conception planning/care, and women typically reach midwives too late for initiating effective NTD prevention with folic acid.

All of these and the other study findings are important. The DELIVER project findings, if acted on can make a difference in the quality of care to women.

Collaboration of Midwifery Science and AVAG

VUmc Midwifery Science and AVAG are inextricably linked. Since the outset of the Midwifery Science Department, every effort has been made to ensure visibility of the Department at the AVAG midwifery academies – both in Amsterdam and in Groningen. The educational program at AVAG has successfully revised their curriculum to enhance the emphasis on evidence-based practice. In addition, midwifery students are required to participate in research projects to promote an understanding of the research process and to ensure that they understand the importance and the pros and cons of participating in research or asking their clients to participate when they are practicing. Midwifery Science researchers and PhDs have contributed to both classroom teaching and to supervising midwifery student research. AVAG has moved forward with the academisation of their curriculum with the goal of seeing midwives undertake their study in the setting with their medical peers – thus transitioning to an academic midwifery program. This will be a critical step in maintaining the standard of maternity care that women in the Netherlands deserve. Care during pregnancy and birth has become, and will likely continue to become more complex. There are more preventative managements to help ensure a healthy outcome such as induction of labour for post-dates

pregnancy, augmentation of a slow to progress labour. Primary care midwives of the Netherlands need to build their skill set to include these preventative approaches. Prenatal care now involves screening of the fetus, and counselling and explaining of various associated risks and benefits. Midwives are required to have a high level of understanding of normal physiology, and of complications, and need to have sophisticated communication skills in order to enter into discussions with peers, with consultants and with the women and families that they care for. All of this speaks to the need for an education at an academic level, undertaken along side their medical peers.

Dutch Canadian relationships

Over the 5 years of my Professorship, a primary focus has been working with the PhD students of the DELIVER study. During my many working visits I had the opportunity to meet with each of my PhD students and their thesis committees to mentor and move their projects forward. I hope that these meetings and discussions were helpful, and feel like I have a good outcome measure... all 4 Midwifery Science PhD graduates whom I supervised have had all their research articles published in relevant peer-reviewed international journals – AND they have successfully defended their work! The remaining 3 students are making good progress. During my visits I held twice yearly "promevendi dagen" for my PhD students –and for other midwifery PhD students who had different supervision arrangements and were within and outside of the VUmc Department of Midwifery Science. Research is lonely work and these meetings offer the opportunity for students to meet and build peer relationships; to bring particular challenges of their work forward; to share "lessons learned"; and as time went by, for those who were more advanced in their studies to provide learning strategies with those starting out. These one-day workshops were a highlight of my visits and I believe they were highly successful in building a system of peer mentoring. I am very pleased to learn that the "promovendi dagen" will continue after my tenure. (about 7 minutes)

In terms of my personal research interests, I feel very lucky to have been approached by clinician researchers in the Netherlands to participate on projects. More than 10 publications have resulted from such collaborations on topics including external cephalic version, umbilical cord clamping and sterile water injections. In terms of knowledge translation, I have been invited to present at workshops on sterile water injection, on twin pregnancy, on primary care and other topics relevant to midwifery clinical practice. All these activities have provided me with the opportunity to do what I love, and to enrich my professional life.

I have also been able to welcome many of the students, teachers and researchers on visits to my home university - McMaster University, in Hamilton, Ontario Canada. During their visits we have had the opportunity to exchange ideas between our jurisdictions on education, research and practice. The most recent visit was organised by a group of 14 midwives from various midwifery practices in the Netherlands who came to Hamilton in June 2015, for a one week "Canadian midwifery intensive". This visit was initiated by former KNOV president, Angela Verbeeten, who worked with McMaster faculty and practicing community midwife, Patricia McNiven.

Community midwives in Hamilton billeted visiting Dutch midwives who spent time at the university, in midwifery practices, visiting birth settings including hospitals and birth centres. Highlights included the visit to McMaster University Midwifery Program, and in particular the anatomy lab – a world class facility; a visit to the aboriginal community of Six Nations of the Grand to visit the maternity care and birth centre; discussions at the Association of Ontario Midwives and the regulatory College of Midwives of Ontario; and a research and educational symposium with presentations from Dutch and Canadian midwives. The symposium acted to enhance the long-established bond between our midwifery communities and was well attended and enjoyed by Ontario community midwives, educators and students. Perhaps the most significant outcome of this visit is the formation of the "Hamilton Group" of midwives here in the Netherlands who are exploring ways to implement some of the ideas that they were exposed to in Canada. Ideas such as improving continuity of care for women by limiting the number of midwives that each woman sees

during her care; expanding aspects of primary care to include, not just providing care in the absence of pathology, but taking steps to prevent pathology; shifting to providing informed choice to women by providing counselling as opposed to simply information giving. The hosting Canadian midwives were also inspired by their Dutch colleagues, and it is likely that an exchange visit will occur in the future.

So, my Professorship has led to many rich and fruitful experiences.

Midwives within the Dutch birthing context The "Dutch Midwifery Situation"

In my inaugural speech, I addressed some of the challenges that were being faced by midwives in 2010. In the years immediately prior to my appointment to Professor of Midwifery Science, the midwifery profession, and particularly midwifery attended home birth was much maligned in the Dutch media. On two successive occasions the Europeristat project reported higher than expected perinatal mortality rates in the Netherlands relative to other European Union countries. Both the media and peer-reviewed journal publications emerged that attributed these findings to the obvious difference in the Dutch Maternity Care system – midwife attended home birth. Criticism of other aspects of primary midwifery care and the echelon system emerged. "Baby Sterfte", "thuis bevallen", "verloskundigen" made headlines -- all with negative connotations. These headlines were being echoed internationally. For example, the British Broadcasting Corporation headline in December 2010 stated, "Controversy over home births in the Netherlands: A debate is raging about where women should give birth". Where are we 5 years later? Many initiatives have been undertaken to address the "Dutch Problem" – inter-professional mortality reviews are being undertaken to identify specific issues; an interprofessional council to focus on pregnancy and childbirth has been established; a number of birth related studies have been funded, including projects to study birth outcomes in the areas of highest socio-economic need. A number of birth centres have opened and are in the process of being evaluated. Integrated care is being implemented in various sites around the country, and these will be evaluated using common evaluation criteria. All of these approaches are likely to contribute to changing the construct of giving birth in the Netherlands. Thus the maternity care system in the Netherlands is changing in response to Europeristat alarm. And we are seeing evidence of that change. More women are giving birth in hospitals; more women are requesting pain management during their births; more midwives are working in secondary care (clinical midwives).

However it is unclear whether these changes have resulted, or will result, in improved care and outcomes for mothers and babies….it is unclear if the changes can address factors contributing to perinatal mortality. Our publication in 2014 showed that the largest differences in perinatal mortality in the Netherlands compared to other EU countries lies in the preterm and particularly the very preterm populations.[2] There are some reasons why these rates in the Netherlands might be different from other countries – there is a higher rate of perinatal mortality among women who have recently immigrated, and the Netherlands has relatively high immigration; there is a lower uptake of early pregnancy prenatal screening in the Netherlands and a higher rate of infants born with anomalies – factors likely to be highly associated. The rate of neural tube defects is high in the Netherlands – and there is no national program of prevention using folic acid.

While it is always important to review practice within health care systems, in the case of perinatal mortality in the Netherlands, it is important to understand the contributing factors and to deliberate the societal views on how to proceed. The biggest gains in improving outcomes will likely come with high level policy change such as funding of early prenatal anomaly screening; implementing public health approaches to folic acid supplementation; considering routine screening in pregnancy for infections such as chlamydia associated with fetal anomalies.

Ironically while the maternity care system here, in the Netherlands, has been scrutinised and with warning signals being sent out about home birth and care with primary care midwives, other jurisdictions are moving to embrace primary midwifery care including home birth as an option for low risk birthing women. On December 3 2014, almost exactly 4 years after the BBC reports alerting viewers to concerns of homebirth in the Netherlands, their headlines stated "Homebirth could be the best option for many women". This headline was based on guidelines from one of the most influential health care institutions internationally – those of the National Institute for Health and Care Excellence or NICE. Despite having perinatal mortality rates for low risk women comparable to the Netherlands, the NICE guidelines indicate that birthing in the UK is very low risk and that care providers should respect women's choice around place of birth.[3] Further, women should be advised that their outcomes may be improved by having care from a primary care midwife in the community – either by planning a home birth, or a birth at a freestanding or along-side (in hospital) birthing unit. This guideline reflects the findings of the large birth-place study that was undertaken in the UK.[4] It is notable that these guidelines garner support not only from the Royal College of Midwives, but also from the Royal College of Obstetricians and Gynaecologists (RCOG) who emphasise the need to support the choice of women. All organisations were able to review the findings of the Birth Place Study showing that low risk women who planned a birth with midwives had improved outcomes compared to low risk women who chose obstetricians for their care. The absence of professional territorial response to the research is commendable.

These Birth Place Study findings should not be surprising given the body of research literature on primary care indicating that at a population level, when first line care is provided by primary care providers (as opposed to specialists), intervention rates decrease, and health outcome improve.[5] Obstetrics is no exception to these findings. It is possible, and even likely that the much higher rates of intervention such as surgical birth observed in countries like Canada (28%) and the United States of America (32%) is associated with the high proportions of low risk women attended by obstetricians. Relatively high rates of obstetrical intervention are found even in settings such as Australia and England where midwives play a large role in the maternity care system, but where they do not typically practice autonomously or in a continuity of care model. This is in comparison to the Netherlands, where midwives provide the majority of care to low risk women, and which is one of the very few countries that would be described as using obstetrical intervention appropriately with a Caesarean section rate of ~17%. It is possible that with increased focus on continuity of care within the midwifery model in the Netherlands there could be an associated decrease in pre-term birth. This might be particularly important among populations where preterm birth is particularly high – immigrant women and women with low social economic status. This will be important to investigate as new approaches to care are being explored.

Over the last few year we have witnessed some peer-reviewed papers vindicating primary care midwifery and the home birth outcomes in the Netherlands, with our own Midwifery Science Associate Professor de Jonge as a principle author on many of these. As a result, in 2015, the media headlines are changing: "Thuis bevallen is toch net zo veilig als in het ziekenhuis" and the sub-title "Het was in 2010 (twee thousand tien) groot nieuws: bij de gynaecoloog is een baby veiliger dan bij de verloskundige. Nu is dat weerlegd."

So, in 2015 perhaps it is easier for midwives in the Netherlands to practice; perhaps women feel more positive about giving birth with midwives in the birthplace of their choice. However, in order to ensure best care for women and for babies, it is imperative that the midwifery research that has begun continues. Midwives must not become complacent; we must examine our practice and hold it up against the standards of the day. Equally important is to have **midwives** undertaking midwifery research so that the right questions get asked, the right methods are used, and the interpretations of the findings are appropriate.

Messages for midwives

It is important to avoid becoming complacent and to remain in a state of watchful waiting. Complacency is easily arrived at. For example, in Canada, in Ontario we have been regulated as midwives for only 22 years – and all midwives do homebirths as part of their care. In fact home birth constitutes between 20-25% of midwives' caseload. Ontario homebirth outcomes have been studied by The McMaster Midwifery Research Group and resulted in one publication in a 2007. The findings (like those of de Jonge here in the Netherlands) found no differences in composite perinatal outcomes for neonates, and were very reassuring. We have just completed a second study of home birth data from Ontario, which has been accepted for publication. To me, this publication felt like a minor achievement, I am happy that the outcomes are reassuring, but I am not surprised. I reflected about the value of undertaking future studies comparing home and hospital birth outcomes. However, in the same week that we got final confirmation of acceptance of the home birth manuscript, I got a copy of an American Journal of Obstetrics and Gynecolgy (AJOG) article suggesting that it is not possible to adequately identify women at low risk during pregnancy and thus women can never be safe to give birth unless they are in a hospital.[6] And later that same day I received an email from a colleague who will be an expert witness in a hearing of the European Court of Human Rights speaking against the case that homebirths are a violation of the rights of the foetus. Clearly, my complacency around home birth research was not warranted!

There is no room for complacency in any profession. It is important to revise approaches to care to reflect new evidence as it arises and the changing needs and expectations of individual clients and of society more broadly. Midwifery is not unique in that regard, but somehow much of what we do seems under threat. My colleagues from social science have taught me that birth is very political! We need strong evidence to support the very essence of what we do; supporting women in giving birth. However, it has been only relatively recently that midwives internationally have begun to contribute to the research knowledge base that drives clinical practice. The Netherlands has begun to make a strong contribution to midwifery knowledge creation. Together the Midwifery Association, the Midwifery Academies, midwifery research networks and Midwifery Science have developed the systems to put the Netherlands on the international map in terms of contributing to knowledge that will improve care of women and babies. It will be important to ensure that the research findings that arise from this important work are put into the hands of midwives. The Kennispoort project and other knowledge translation approaches are likely to assist in reaching the care providers who will benefit from the knowledge. There is evidence of good success in KT – for example the highly successful project undertaken by KNOV to bring ECV to women across the Netherlands with breech pregnancies was evaluated and recently reported in the BJOG. On the other hand, initiatives like the sterile water injection for pain management, which has good research to support it, has been unable to be moved forward, because of restrictions on midwifery practice.

Midwives must keep pushing to understand what is effective in clinical care, and to have changes made to the way they practice as a result of the findings of the research. For example, a review paper in the NEJM from September 2015 reports on Prenatal Factors in Singleton infants born at or near Term with Cerebral Palsy. This paper is very clear that CP is rarely associated with fetal asphyxia; that the use of EFM [electronic fetal monitoring] has not been helpful in decreasing the likelihood of CP; that the enormous increase in surgical delivery has had no impact on CP rates and the paper concludes: "Factors that contribute to both birth defects and poor prenatal growth, such as intrauterine infections, teratogens, and certain genetic syndromes, should come under special scrutiny".[7] This seminal paper also points out that many Obstetrical Societies have indicated that "there are no long-term benefits of EFM as currently used".

This paper is a good reason to give pause to consider the direction of maternity care in the Netherlands. Moving more births out of primary care is likely to be associated with increased interventions including increased caesarean section, without particular benefit to neonates, and with increase in harm to women. Furthermore, the rate of birth defects in the Netherlands is higher than in other EU countries – we have evidence from the DELIVER study that can

impact these rates: In her research as part of the DELIVER study, Pereboom focused on some common infections of pregnancy and considered what midwives know about them, what they tell their clients and what their clients know. She identified some clear gaps and has made suggestions as to how these can be filled. The challenge for Midwifery Science, the Midwifery Schools and the KNOV will be to see how these recommendations can be implemented in order to improve care for women and infants. Gitsels and Martin both address aspects of perinatal screening and counselling, in terms of what women wish to know, and how midwives are addressing those needs. Again recommendations were made. It is imperative that we develop the mechanisms to move research findings from the printed pages into midwifery practices in order to take the next step in enhancing care.

Conclusion:

It has been 8 years since the first visit by the AVAG team to McMaster University asking about how to develop a program of research – and much has happened since that time. I pay tribute to those who had the vision and the courage to put a plan in place to bring The Netherlands in line with midwifery researchers internationally. And to all of the many who believed in and supported that vision. You have met with great success, and have made a major contribution not only to midwifery knowledge, but also to the health of the profession in the Netherlands. Most importantly you have the capacity to improve care for women and families in the Netherlands.

My decision, not to renew as Professor of Midwifery Science was not for lack of interest in, or stimulation from, the position. It was not from lack of support from my Dutch or my Canadian peers. My role has been part-time with only intermittent visits to the Netherlands, and it is my belief that the position merits someone who is embedded in the Dutch culture – who can remain current in the issues of the day – who can fully understand the subtleties of practice in this environment and who can provide a day-to-day presence. Thus my decision to leave this valued position was based on my belief that, if I were to continue in the position, the full potential of the Professorship position would not be reached. In my opinion I would stand as an impediment and block important opportunities for development of leadership capacity within the Dutch midwifery community. And so, it is with some regret, but with full confidence in Midwifery Science that I take my official leave today.

Let us take this day to celebrate Midwifery Science in the Netherlands, and to recognise the contribution of the many who have contributed to the incredible success of the DELIVER Study, AVAG and the Department of Midwifery Science at VUmc and EMGO+... successes, which will help midwives keep women at the centre of care.

Thank you

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Thank you

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To the AVAG board who has wisely invested in Midwifery Science and thereby in the future of midwifery and best care for women and infants in The Netherlands,

To the midwives of the Netherlands who willingly participated in midwifery research and who provide care to the thousands of women and their babies born here each year,

To the women who participated in the research projects, and finally

To my family and colleagues in Canada who released me from obligations at home, and to the many others who have contributed to my tenure in this professorship position.

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Department of Midwifery Science
of the EMGO Institute for Health and Care Research at the VU Medical Center and the AVAG Midwifery Academy Amsterdam Groningen, the Netherlands

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