Women and Birth 38 (2025) 102122

Contents lists available at ScienceDirect

Women and Birth

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

Exploring values and ideologies of Dutch community midwives, a qualitative study

Esther Feijen-de Jong [a,b,c,*,1], Billie Hunter [d], Beth Murray-Davis [e,f,g], Elizabeth Kool [a,b,c]

[a] University of Groningen, University Medical Center Groningen, Department of Primary and Long-term Care, Groningen, the Netherlands
[b] Midwifery Academy Amsterdam Groningen, InHolland, Groningen, the Netherlands
[c] Amsterdam UMC location Vrije Universiteit Amsterdam, Midwifery Science, Amsterdam, the Netherlands
[d] School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, Cardiff, Wales, United Kingdom
[e] McMaster Midwifery Research Center, McMaster University, Canada
[f] Department of Obstetrics and Gynecology, Midwifery Education Program, McMaster University, Hamilton, ON, Canada
[g] Limited Term Chair in Midwifery Research, London Health Sciences Centre, London, ON, Canada

ARTICLE INFO

Keywords:
Midwifery
Community care
Values
Ideologies
Professional identity
Interprofessional collaboration

ABSTRACT

Aim: To investigate potential conflicting values and ideologies among Dutch community midwives, aiming to develop practical, organizational, and educational strategies to reduce attrition.
Design: Qualitative research within a constructivist paradigm
Methods: Semi-structured interviews with community midwives from both group and solo practices in Dutch midwifery care were conducted to achieve maximum sample variation. Data collection and thematic analysis took place iteratively from March to June 2023.
Results: Participants identified core values and ideologies in Dutch community midwifery: client-centered care, autonomy, empowerment, connections, tailored care, and professional development. They prioritize high-quality care, reflection, continuous professional growth, and well-being. Internal or ideological conflicts with colleagues or parents can challenge these values.
Conclusion: Our findings emphasize the ideologies and core values that guide community midwifery in the Netherlands. Navigating complex value conflicts and resource limitations necessitates continuous reflection on their effects on professional well-being and sustainable practice.
Implications: Midwives worldwide need to be aware of and consistently reflect on their professional values to reduce conflicts and improve the quality of care. These values are fundamental to the profession, making it crucial for midwives to adjust their practice accordingly.
The ideology of Dutch midwifery, emphasizing client-centered, personalised care and the physiological process of pregnancy and birth, may face challenges during interprofessional collaboration and when resources are limited.
Understanding midwives' ideologies is essential for reducing miscommunication and misalignment within the profession. Professional values are fundamental to midwifery and should be taken into account during organisational changes. Engaging in discussions about these values in education and practice enables midwives to remain committed and satisfied, enhancing professional retention.

* Corresponding author at: University of Groningen, University Medical Center Groningen, Department of Primary and Long-term Care, Groningen, the Netherlands.
E-mail addresses: e.i.feijen-de.jong@umcg.nl (E. Feijen-de Jong), HunterB1@cardiff.ac.uk (B. Hunter), bmurray@mcmaster.ca (B. Murray-Davis), e.kool@umcg.nl (E. Kool).
[1] Postal address: UMCG, Hanzeplein 1, 9713 GZ, Groningen, the Netherlands

https://doi.org/10.1016/j.wombi.2025.102122
Received 23 July 2025; Received in revised form 21 October 2025; Accepted 21 October 2025
Available online 31 October 2025
1871-5192/© 2025 The Author(s). 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

There is limited research on the professional values of Dutch midwives, despite these values being key to shaping their practice and professional identity.

What is already known

Awareness of professional values can foster positive interprofessional collaboration and enhance workforce retention.

What this paper adds

Understanding midwives' ideologies is vital for reducing miscommunication and misalignment within the profession. Professional values are core to midwifery and should be considered during organisational changes. Discussing these values in education and practice allows midwives to stay committed and satisfied, enhancing professional retention.

Reporting method

We used the Standard Reporting Qualitative Research items.

Patient of public contribution

This study did not include patient or public involvement in its design, conduct, or reporting.

Introduction

The midwifery workforce in the Netherlands is struggling to retain qualified midwives [1]. Dutch research revealed that 33 % of midwives are considering leaving the profession [1]. Internationally, the intention to leave midwifery ranges from 30 % to 68 % [2–4]. This is a major concern as it can lead to a shortage of midwifery staff and thus affect the availability and quality of care provided. Research shows that even the intention to leave a job puts a strain on the provision of care, as people tend to experience withdrawal reactions, with a range of consequences for the care provided [5].

Factors influencing midwives' well-being and decisions to stay or leave the profession include care organisation, professional autonomy, social support, and personal circumstances [6–9]. In the Netherlands, ongoing changes in midwifery care—particularly the shift toward integrated, interprofessional collaboration—pose challenges that may impact retention [1]. While such collaboration offers opportunities, it can also create ideological tensions that affect professional identity [10]. Additionally, work-life imbalance, long shifts, and on-call demands may conflict with the provision of personalised care [1]. Conversely, a strong professional identity and alignment with professional values enhance job satisfaction and support retention [11,12].

Professional identity is a construct in which the internalisation of professional beliefs, values, and behaviours determines the behaviour of actors [13]. Identification with the professional group, therefore, helps to develop competent and confident practitioners and provides a sense of belonging [13]. However, a strong professional identity may also lead to tensions when working in a practice setting where multiple ideologies need to be reconciled. For example, when health professionals are required to work in interprofessional teams, a major concern is attributed to the interprofessional conflict based on one's professional identity [14,15]. In addition, threats also arise when professional values and ideologies conflict with personal values or institutional needs [16,17]. This could have consequences for midwives, resulting in internal conflicts and decreased engagement, along with withdrawal behaviour.

In midwifery, these tensions are particularly relevant as professional values play a crucial role. The International Confederation of Midwives (ICM) emphasises that pregnancy and childbirth are usually normal physiological processes of great importance to women, families, and communities. Midwifery values include respect for self-determination, personalised and continuous care, and a non-authoritarian approach [18]. The 2014 Framework for Quality Maternal and Newborn Care highlights core values such as respect, communication and understanding of the community and advocates for care tailored to women's needs [19]. The Royal Dutch Association of Midwives (KNOV) similarly values the midwife as a personal, continuous care provider and views childbirth as a natural process, usually free of complications [20]. However, there is limited research on the professional values of midwives in the Netherlands. Understanding these values is essential, as they form the foundation of midwifery care and influence how midwives navigate their professional roles and align their work with their professional identity [17].

This study explored possible conflicting values and ideologies in the Netherlands to develop practical, organisational, and educational strategies for midwives to use in practice to prevent attrition. Therefore, we created the following research question: What values do community midwives in the Netherlands hold, what ideology do they adhere to in their practice, and do they perceive conflicting professional values in midwifery?

Methods

Within a constructivist paradigm, we conducted qualitative descriptive research using semi-structured in-depth interviews to gain a deep and rich understanding of this research topic.

Researcher characteristics and reflexivity

To minimize researcher influence on the research process and outcomes, we assembled a multidisciplinary team. The first and last authors conducted the fieldwork and engaged in reflective discussions with the team. EF-dJ, an academic midwife and experienced qualitative researcher, and EK, an educational expert with a Master's in Educational Science, led the data collection. Two midwifery researchers from the UK (BH) and Canada (BM-D) provided critical feedback. BH specialises in the cultural and emotional dimensions of midwifery, while BM-D focuses on interprofessional collaboration and identity formation in maternity care.

Sampling strategy

We included midwife participants working in Dutch community midwifery care, recruited through multiple strategies. First, we used our professional networks to contact midwives nationwide via email, text, and phone. To ensure maximum variation, we included midwives from both group and solo practices, with varying years of experience. As interviews progressed, it became clear that many had structured their work to avoid value conflicts. We therefore used purposive sampling to include midwives expressing job dissatisfaction.

Ethical issues

This research was approved by the Ethics Review Board of the University Medical Center Groningen (nr. 2023/062). We guaranteed participants' confidentiality and assured them they could withdraw from the study at any moment.

Data collection

Data were collected iteratively between March and June 2023, with analysis starting in May to inform subsequent interviews. After obtaining written informed consent, participants were interviewed in person or online at a location of their choice. A brief background questionnaire was sent in advance. Interviews were recorded with consent, anonymised, and transcribed verbatim. We conducted all interviews and

Dutch midwifery care (see Appendix 1)

In the Netherlands, midwifery practice has evolved since its foundations in 1865. Until the late 1980s, most midwives worked solo with a caseload of 165 per year; by 2016, only 5 % worked alone with a caseload of 105. Today, the majority of primary care midwives work in group practices comprising three or more midwives in community care settings. The Dutch maternity care system is divided into primary, secondary, and tertiary care, with community midwives providing primary care for normal physiological pregnancies.

According to national figures, 72 % of midwives work in community-based settings, while 28 % work in hospital-based settings. Community midwives can decide how many clients to take on and how much time to spend with each client, as they are self-employed. Practice assistants help with administrative tasks, and women are referred to the hospital if there is a risk of adverse outcomes or complications during pregnancy or childbirth.

transcripts in Dutch. The quotes in the results section were translated into English using AI assistance (Copilot and Grammarly within the secure university work environment). Interview topics (Appendix 2) were based on existing literature on professional identity, including values and ideologies [18–20], and grouped into five main areas: [1] professional behaviours and activities, [2] knowledge and skills, [3] values, beliefs, and ethics, [4] context and socialisation, and [5] group and personal identity. After the first three interviews, we added topics on conflicting values and ideologies to better address the research question. No further changes were made to the data collection tools.

Data analysis

Data analysis began with text condensation to preserve core meaning [21], followed by categorisation of fragments. Many categories reflected values, while others captured essential aspects of midwifery considered important by participants. These were grouped under the overarching theme of midwifery ideology related to the profession. LK and EF-dJ jointly analysed the data, reaching consensus through discussion and memoing. EF-dJ and EK independently open-coded the first two interviews, identifying fragments relevant to the research question. This informed the coding of six additional interviews by EK and EF-dJ. No new categories emerged in the final two interviews, indicating inductive thematic saturation and ending participant recruitment [22].

Results

We interviewed 14 community midwives. Interviews lasted between 1 and 2 h. The midwives practised midwifery in all parts of the Netherlands and graduated between 1989 and 2018. The number of full courses of care[1] per midwife also varied, ranging from 40 to 70 full courses of care per year. Table 1 shows the demographic characteristics of the participants.

Table 1
Demographic characteristics of participants.

Mean age (range)	45 [34–62]
Year of graduation	6
1989–1998	4
1999–2008	4
2009–2019	
Years of practice	5
0–10	4
11–20	5
≥ 21	
Employment status	13
Self employed	1
Locum	
Number of midwives in practice	5
Solo	3
Group (2–4 midwives)	6
Group (5 and more)	

The interview data were organised into three themes: midwifery ideology, professional values, and conflicting values.

Theme 1: Midwifery ideology

Participants identified four fundamental concepts that define midwifery ideology, reflecting a shared perspective on what constitutes a 'good midwife'.

Supporting physiology

Participants emphasised the importance of perceiving pregnancy and childbirth as normal, healthy processes, relying on the body's natural ability to function as intended. The physiological process was considered essential for achieving optimal outcomes and providing a healthy start for the child. One midwife expressed this best: *"Yes, but because I still want to work from a physiological point of view. I just want to propagate that very much, whereas nowadays I think it's a bit different with people. I want to propagate that they are pregnant. You often get pregnant when you're healthy and you're healthy and you stay healthy. And in terms of prevention, I also try to get the message across in the consultation that if you change your eating habits now, or something like that, you will take that into account when you bring up the child […] Prevention and physiology actually go hand in hand."* (P7, LGP[2])

Enhancing women's choices

Enhancing women's choices was considered fundamental to midwifery ideology. This included supporting couples throughout their entire transition to parenthood, as well as the choices involved. Participants also shared their conversations with parental couples about the necessity of interventions during pregnancy and childbirth. The midwife's evidence-based information and encouragement of shared decision-making formed the foundation for promoting women's choices as articulated by one participant: *"Then we talked for a very long time about: do we go ahead with this induction? because it's not medically necessary, I talked to them for an hour about it. They decided to go ahead with the induction, even though they knew what the disadvantages might be. …. She was just able to make that decision and had all the knowledge to do it. That was good."* (P2, SP[3])

[1] Courses of care, see explanation in Appendix 1.
[2] LGP refers to a Large Group Practice > 5 midwives
[3] SP refers to a Solo Practice

Fostering empowerment of women

Participants shared their expectations and hopes that their involvement with pregnant women would lead to a positive childbirth experience. In turn, this positive experience empowered women as individuals and as mothers: "*I also want a woman to feel stronger after giving birth to that child than she did before"*. (P2, SP)

Comprehensive care

Participants expressed their vision of collaborating with pregnant women, considering both medical and psychosocial perspectives within their environments or contexts. *" I can't see how your baby is doing in your belly with my X-ray eyes. If you have a conversation like that, you can really connect with people on a deep level. But what risks are you [client] willing to take and what feels acceptable to you? …that is something you will discover with people during pregnancy"*(P12, SGP[4])

Theme 2: Values in midwifery

To make values visible in our interviews, we first explored midwifery norms: How does a 'good midwife' behave? By posing these questions, we uncovered professional values that were sometimes vaguely expressed and other times quite obvious. Table 2 provides a summary of values, an explanation, and quotes from the midwives. Given the wealth of data on this theme, we have chosen to present it in a table format for ease of reading.

Theme 3 Conflicting values; balancing professional and personal wellbeing

Participants shared extensive conflicts—both internally between personal and professional values, and externally with colleagues, other professionals, and clients. These conflicts underscore the complex dynamics and interplay between professional values, personal values, and external pressures that shape the experience of midwives in their practice. Below, we outline these conflicts under two headings: first, perceived internal conflicts experienced by midwives themselves; second, perceived conflicts with clients, obstetricians, fellow midwives, and health insurers.

Conflicts within themselves

Participants felt a conflict between protecting their personal well-being and upholding their professional values, especially when providing individualized care to women. They acknowledged the personal toll this can take but also expressed a strong desire to be service-oriented and available for their clients. This internal conflict was highlighted when participants felt uncomfortable with clients phoning about personal problems, revealing a struggle between providing care and maintaining personal boundaries. This was summarized by one midwife who stated: "*But yes, on the other hand, to be of service is also to be very much giving of yourself, isn't there a kind of contradiction in that, in your values perhaps? You also say, gosh, I want to be very helpful and people don't call just like that, but on the other hand you also say: Yes, but sometimes I find it unpleasant [that people call] because then they call with this and that and it bothers me (P6, LGP)*". Additionally, the stress of personal perfectionism and high self-expectations can interfere with effective care and negatively affect midwives' wellbeing: "*I'm the type of person who has very high standards. Thus, a true perfectionist, which I detest greatly*." (P11, LGP)

The conflict between professional values and attitudes toward self-care and boundary-setting in the profession was intensified as participants felt pressured to remain constantly available and to prioritize service delivery over their well-being. Some participants experienced such high internal conflict that they decided to change their career

Table 2
Professional values, explanations of professional values and related quotes of community based midwives in the Netherlands.

Value	Explanation from the perspectives of participants	Quote
Providing personal, tailored care	Tailored care, respectful of women's autonomy and preferences, is essential during childbirth. A key factor contributing to job satisfaction among midwives is the personal connection established with women, fostering trust and enabling effective, individualised care.	*That you just look at the person and see what they need. And that you take your time and don't want to rush it. Because then you miss things. Really take your time and assess each person as, as a unique person. And that includes protocols, but sometimes you can deviate from that. Yes, really listen to what the person wants.*(P13, LG)
Professional /Occupational Autonomy **Independently autonomous Autonomous independent**	Participating midwives perceived autonomy in two aspects: [1] Professional independence, characterised by self-directed decision-making, accountability, and (self)-confidence; and [2] Autonomy as an independent practitioner and practice owner, encompassing the ability to lead in clinical situations, maintain professional integrity and identity, and provide care as a small team.	*"If, during our conversations, I notice that someone isn't willing to take responsibility for their own care, I start to question whether I'm the right care provider for them. That's something we need to talk about openly. People need to decide whether they're comfortable leaving that responsibility with me—or we may need to acknowledge that we're not the right fit for each other."(P12. SGP)* *But I believe very strongly in autonomy. I think we [midwives] have the best right to exist for the sake of physiology and the birthright of the child. And especially that we should remain autonomous. And that we can really position ourselves from an entrepreneurial point of view. But it does require something. How it relates to the current market forces. Which I find very thrilling.* (P5, SGP)
Collaboration with colleagues and women	Midwives described collaboration as: 1. Building trust and responsibility among team members and between professionals and pregnant women, creating a positive and joyful environment. 2. Recognising individual strengths and abilities enables effective teamwork, particularly across primary and secondary care settings. 3. Organisational collaboration involves coordinating efforts with other practices, sharing responsibilities, and discussing progress to achieve shared goals. 4. Collaboration also involves empathetic relationships with pregnant women, demonstrating a genuine	*We just have a good time together with the [practice]-assistants*[10]*, which is nice, and we have lunch together every Thursday afternoon, and then we discuss everything. Of course, we sometimes disagree, but yes, we all really want to take good care of our pregnant women. We go through fire and water for each other, you know, it's in busy times, even at the weekend, … are you going to make it in the shift, do I have to step in? […] Yes, it works very well, I have to say.* (P6, LGP) An obstetrician said to me last year or two years ago, when we had a brief discussion, "Are there things that could be improved in the hospital where I work and in our

(*continued on next page*)

[4] SGP refers to a Small Group Practice < 5 midwives

Table 2 (*continued*)

Value	Explanation from the perspectives of participants	Quote
	understanding and vulnerability.	collaboration? And then I asked, 'How do you actually see me? And then he said, 'Yes, you're still a real old-fashioned midwife," and then I thought, 'What do you mean, old-fashioned midwife? And that was really what you're saying now, you stand up for your people. You go along with your people, you stand up for your people and you're really there for them. So people really benefit from you. (P10, SP) [being on-call for each other's practices] We make convenient schedules for that. And there are never any problems with that; people always come when you call them, or vice versa. Helping each other out with shifts during the coronavirus pandemic when people are off work. Things like that, really, working together to create new protocols. Perhaps CTG in primary care, which is something we are currently working on. That is something you want to tackle together with all midwives.(P7, LG)
Expertise	Competence encompasses continuous development and maintenance of knowledge and skills necessary for professional practice. While theoretical foundations are crucial, practical experience and clinical reasoning are also essential. Midwives highlighted the importance of social and empathic skills in responding to individuals' needs, as well as the ability to provide care in acute situations. Staying alert and maintaining expertise through continued exposure to various scenarios, such as home births, is vital for ongoing competence.	*"It is not only medical, it is also psychosocial. And to be able to do that, I think you have to learn the profession, you have to learn it well at school [midwifery education], so you just have to know your subjects, you have to pass your exams, you have to meet all the requirements that the management sets. Well, and then of course you get more and more into that world, and in the meantime you learn a lot even if you have already graduated. I think even more than the training itself.* *I always say to someone who joins us …. that they can learn a lot of things with us, huh, I think, for sure, but also a lot of things that they cannot learn. If you start working. Please go and work in a large practice, where they have two teams, so that when you're on call there's always someone else on call too, you have colleagues you can bump into and you're not alone, you know.* (P3, SGP)
Providing a service/ to serve/care for	Participants emphasised that genuine interest in pregnant women and recognising their unique circumstances are essential aspects of practice. They also highlighted the importance of flexibility in work-related activities, including being available for work and being willing to work shifts. A commitment to continuous development, assuming responsibility, and embodying these values as part of the profession's identity were seen as fundamental to a midwife's role.	*I think we are at the service of the people we work for, and that is the pregnant women, but also their partners, their families, and I think whatever you do for them, you have to do it well. That means that you have to meet the wishes of the person you are caring for as well as you can.* (P6, LGP)
Connecting with people	This value has been articulated in many ways. It means working with pregnant women and with women, being close to someone, being important to someone, and getting to know people better. Regarding collaboration, it is explained as getting to know and being with your collaborators.	*Yes, I think it is very important. You also see that they can open up more easily during childbirth because they know you better. I think they get more confidence.* (P13, LGP)
Quality improvement	Improving the quality of care is an important value identified by midwives. This lies not only in the individual but also in the team. Through specialisation or the use of each other's qualities, not everyone has to do the same thing, but one can use each other's specialisms to improve the quality of care. It is also more efficient and takes advantage of the diverse skills and interests of the different midwives in the team, highlighting their complementary strengths.	*It [quality improvement initiatives] has transformed the way we work and has significantly improved our outcomes.* (P2, SP)
Wellbeing, self-care	This involves taking good care of yourself and paying attention to your needs. You do this by living a healthy lifestyle, including eating well, getting enough sleep, and taking breaks. This helps in managing irregular working hours and caregiving responsibilities. Talking about work with others also gives space and air to move on.	*… but also takes good care of themselves. And I think that's also something you see in the workplace, of course, people who just go on and on and on. It's such a cliché, but if you don't take care of yourself, you can't take care of others. I think that also makes you a good midwife, so that you are there for your client, but also really there for yourself.* (P4, LGP)
Authenticity	Participants point out that it is important to have a congruent attitude towards pregnant women; this means being yourself in your work. And then being at peace with the fact that colleagues are different and do things differently.	*I also think that if I do my job the way I am, you don't have to act, you don't have to pretend to be different, you can really be yourself, it takes a lot less energy, you have a lot more fun at work, at your job. Then you don't have to think so much about how should I do this? Or how should I do this? You just do it. So it becomes*

(*continued on next page*)

Table 2 (*continued*)

Value	Explanation from the perspectives of participants	Quote
		more and more second nature. As a result, it just becomes easier and more fun. (P10, SP)
Courage	To be able to stand up for pregnant women, to be brave enough to stand up for your profession in the best interests of pregnant women.	*…And then I came to her when she was in labour, and I walked in, and she already had the urge to push, so I listened. I hear something so wrong that I am utterly shocked myself. I think, oh dear…. Should I call an ambulance after all? Because if something goes wrong, I'll be blamed for not calling an ambulance. But will it help her to have an ambulance waiting outside?. And at a certain point, I decided I wasn't going to call an ambulance. and then her waters broke …. I regained all my confidence. In the end, she gave birth. … Because then I knew. That was to keep calm and assist her with her delivery on the spot. (P1, SP)*

[10]A practice assistant is someone who takes telephone calls, performs administrative tasks, schedules appointments and takes blood samples or measures weight.

direction. They expressed that working in large midwifery practices with many full courses of care created a strong internal conflict between wanting to provide personalised care and maintaining their wellbeing. As a result, they decided to work as a solo midwife with fewer full courses of care per year, allowing them to provide continuous personal care with increased wellbeing: "*I felt much more free than in group practice and did not have to recover from busy shifts,….*" (P9, SGP)

Participants also faced conflicts between their professional tasks and their personal lives. The increasing administrative burden interfered with personal care and time, leading to struggles maintaining a healthy work-life balance. Moreover, family needs potentially conflicted with providing personal care and service, with the pressure to work night shifts and the physical demands of the job interfering with family responsibilities.

The 'protocolization' of care and the expectations of professional autonomy they perceived to be imposed on them were also expressed as a source of conflict. Some participants felt that increasing protocolized care conflicted with their midwifery ideology and, ultimately, job satisfaction: *"We have had training. We have a vision, um. We know what physiology is, more than any profession. Don't let that get snowed under (by protocols). And certainly not to be glossed over or ridiculed.*" (P1, SP) Existing protocols limited the freedom to create personalised care pathways, and dealing with increasing administrative and regulatory burdens was described as overwhelming. This conflict was evident in the quote, *"You have to be so engaged. So many demands are placed on you."* (P7, LGP)

Conflicts with others

Clients

Participants experienced ideological conflict when clients relied heavily on their guidance, while they aimed to support autonomous decision-making. Tensions also arose when the client's wishes diverged from standard practice. Responses varied: some deviated from guidelines and faced resistance from colleagues; others engaged in dialogue but were sometimes unable to fulfil client needs and requests. Both situations compromised the professional value of individualized care, and participants perceived these tensions as uncomfortable.

Policies

Participants described conflicting professional values regarding risk management. They highlighted that obstetricians may take a more cautious approach, focusing on minimising risk through standardised procedures. In contrast, midwives may want a more personalised approach that recognises individual women's circumstances and preferences. This discrepancy in risk perception highlighted the tension and disagreement between providing personalised care based on individual preferences and the cautious, risk-minimising strategies often favoured by medical professionals: *"It's interesting how we often find ourselves discussing this with obstetricians, right? We might feel they view things from a more medical, pathological perspective, while they might see us focusing too much on the physiological aspects instead."* (P7, LGP). This was seen as having negative implications for trust and collaboration between participants and obstetricians, even though midwives value collaboration.

Another quote illustrates the tension midwives may feel in conflicting between good care and protocols: "*Women can give birth. They need the context and security of someone or a place where they are given the time to give birth with confidence. Yes, and often we take away that confidence, we take away all the time. Everything has to be incredibly fast, faster, faster. The placenta almost has to come first. Really, you see, now the placenta has to come within half an hour. […] I think it's 'how to spoil a good birth*". (P1, SP).

Conflicts in collaborative working

Participants encountered conflicts with midwives in their practice as well as with midwives from other practices, primarily because of differing opinions on the best way to achieve optimal delivery of care. For example, introducing new approaches to care caused tension between colleagues who resisted change or had different opinions about implementing innovative practices. All participants mentioned the importance of continuity of care. However, many participants mentioned feeling stressed and pressured by the midwifery profession to provide continuity of care. This created an internal conflict between their feelings about being on call, the stress this causes, and meeting the standards of continuity of care. "*I think a lot of them think the same way I do. But I don't know exactly who comes up with this continuity, but in the profession people also think: "What have they come up with now?*"*(P7, LGP)* Conversely, one participant reflected on a conflict between her professional values and how newly qualified midwives or students choose to work. This was also apparent in how they viewed recently qualified midwives, who they felt let down the profession for putting their workload ahead of the need for continuity of care: "*I realised that this was important to me, and that I was sometimes disappointed by new locums or students who would say 'I won't take part because I've already been very busy'*. (P11, LGP)"

Conflicts due to practical issues

Workplace challenges related to human resources and staffing capacity created conflict between participants' professional values and the practical constraints they faced. The shortage of supporting staff members hindered participants' ability to provide care according to their values. This conflict highlights the challenges of maintaining quality care with resource limitations. In addition, the lack of maternity care

assistants[5] leads to problems sustaining and providing births at home. A participant expressed a conflict between wanting to provide personalised care and, at the same time, feeling uncomfortable attending home births without the support of a maternity care assistant due to staff shortages: "*There are times when it is really very nice to have a maternity care assistant present, and this can make it more difficult for people to choose a home birth, simply because there is no maternity care available.*" (P12, SGP)

Financial factors substantially contributed to tensions between participants and the healthcare insurance system. Despite the available evidence on the effects of specific care models, such as caseload practices, there was a perceived lack of recognition and appreciation for their cost-effective nature. Some participants also expressed discontent about the growing influence that health insurance companies exert over women's care direction. The participants underscored the importance of autonomy in clinical decision-making and the ability to deliver individualised care based on their professional expertise. Furthermore, they experienced conflicts regarding autonomy, driven by the administrative burdens imposed by health insurance. The quote: *'It's almost impossible to do anything anymore, including independent meetings with insurance companies'* (P7, LGP) highlights the challenges of managing administrative tasks independently.

Discussion

This study explored possible conflicting values and ideologies in the Netherlands, aiming to develop practical, organizational, and educational strategies for midwives to use in practice to prevent attrition. Midwives prioritise providing personalised, tailored care, autonomy and collaboration with others. They value autonomy and strive to empower clients through their care. Lastly, midwives' well-being and self-care were highlighted as important values for midwives. The realities of practice can challenge these values. For example, protocols and policies may limit women's choices, and workplace challenges like staffing shortages and financial constraints can impact the ability to provide personalized care. Midwives also face frustrations with the healthcare insurance system, which affects their autonomy and increases administrative burdens.

Midwifery ideology in the Netherlands appeared to be a shared and overarching concept that aligns with Renfrew et al.'s framework [19]. It encompasses principles such as physiological grounding, promoting women's autonomy in decision-making, fostering empowerment, and providing comprehensive care. Pregnant women highly value this "with-woman" philosophy [23], and it has been demonstrated to enhance the well-being of midwives [24]. However, as Feeley has studied [25] it is important to recognize that there can be variations within this philosophy. On one end of the spectrum, some midwives fully support women's autonomy and easily deviate from standard care, while on the other end, some midwives adhere more strictly to guidelines. This can lead to misunderstandings and tensions within the profession, highlighting the need for midwives to explore where they stand on this spectrum [25,26].

Our study aligns with Feeley's holistic concept of midwifery as a 'skilled heartfelt practice' [25] and the 'primacy of a good midwife' theory of Halldorsdottir and Karlsdottir [27], which emphasizes the balance between personal and professional values. A 'good midwife' integrates competence and wisdom, personal and professional development, professional caring, and interpersonal competence. These theories can serve as fundamental building blocks for professional midwifery care and support the development of a professional identity.

Providing personalized care is a fundamental priority for Dutch midwives, who strive to tailor their services to each individual's needs and preferences while emphasizing respect for women's autonomy and choices during childbirth. This approach aligns with the concept of woman-centred care, which represents each woman's unique, individualized care; however, research by Crepinsek et al. [28] has found that this concept is rarely mentioned in the professional standards documents that guide midwifery [28]. Our study demonstrated that midwives strive to deliver personalized care to uphold autonomy. Although they do not explicitly use the term "woman-centred care," they still work to practice its principles.

Our findings reveal both internal (personal) and external (client and interprofessional) conflicts faced by midwives. Participants stressed the importance of personalised, woman-centred care, which demands availability and presence. However, balancing this with family responsibilities created internal tensions. Such conflicts are common in female-dominated professions, where professionals often navigate competing roles, leading to family–work interference [29,31,32]. These challenges are particularly pronounced in healthcare, where practitioners' altruistic commitment to women intensifies the strain [30].

Conflicting values may pose a challenge in interdisciplinary collaborations and work environments. Midwives may struggle to maintain their values if the environment does not align with their principles or when faced with varying standards and behaviours. To mitigate this, they may adapt their practices to reduce dissonance. For example, some midwives in our study opted to care for fewer women, prioritising overall well-being instead [26]. Conflicts can occur when personal values shift over time or clash with professional demands. This may lead to internal tension and negatively affect midwives' well-being. Research suggests that poor well-being can impair cognitive functioning and emotional resources, which may in turn hinder professional performance [33].

Strengths and limitations

This study is the first to explore midwifery values in the Netherlands and provides a basis for further research. We interviewed a variety of community midwives and achieved data saturation, which makes the results credible for the Netherlands.

However, it should be noted that we only included community midwives in our study, so the values held by hospital midwives and the conflicts they face have not been explored. Although core values may be consistent between the two groups because they have the same educational background, we hypothesize that the conflicts may differ due to the work context. This requires further research.

Implications

We recommend that midwives explore their ideologies regarding midwifery care, from conventional to holistic approaches. In midwifery practices, it's essential to share and reflect on the positions of individual midwives along this spectrum to minimize miscommunication, prevent misalignment, and reduce attrition in the profession.

Professional values are at the heart of the profession. Underpinning work with professional values should ensure that midwives continue to enjoy their work and remain committed to the profession. Therefore, it is important to consider these values when changes are made in the organization of care.

In this research, we explored professional values without ranking or prioritizing them. Future studies are recommended to understand potential hierarchies among these values. Such findings will provide insights into differences in clinical reasoning processes and potential conflicts between professionals.

The use of theoretical guidance is essential in researching professional values in science. Internationally, frameworks like Renfrew's model [19], Feeley's model [25], and the theory by Halldorsdottir and Karlsdottir [27] promote discussions on how professional values relate

[5] Maternity care assistance is a distinct aspect of the Dutch maternity care system. They support the midwife during birth and also provide help to the mother and child for about 48 h over the course of 8–10 days postpartum.

to the organization of maternity care in various countries. In the Netherlands, for example, community midwives often function as independent practice owners. This independence affects their capacity to implement changes within their contexts and settings, requiring alignment with secondary care providers. As a result, midwives can adjust their practices to reflect their professional values, which grants them control and autonomy. However, they must also collaborate within the regional standards of maternity care, which may deviate from the care they wish to provide.

Professional values should be discussed in the education of midwives. This discussion is crucial because values become internalised and influence the standard in practice and guide students' behaviour. Educational settings provide a unique opportunity to teach, modify, and promote these values [34]. Without these discussions, an implicit hidden curriculum may influence the formation of students' professional identities.

Conclusion

Our findings highlight the ideologies and foundational values that guide community midwifery in the Netherlands, such as autonomy and personalised care. Dutch midwives navigate complex internal and external value conflicts during their work. Policies and resource limitations can impact their ability to align their practice with their values. Addressing these challenges necessitates ongoing reflection on the influence of these values on professional well-being and sustainable practice. Midwives worldwide must be aware of and continuously reflect on professional values to mitigate conflicts and enhance the quality of care. These values are central to the profession, making it essential for midwives to adapt their practice accordingly.

Author declaration

The authors declare:

- that the article is the author(s) original work
- the article has not received prior publication and is not under consideration for publication elsewhere
- that all authors have seen and approved the manuscript being submitted
- the author(s) abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives

CRediT authorship contribution statement

Esther Feijen-de Jong: Conceptualization, Methodology, Formal Analysis, Investigation, Writing – Original Draft **Elizabeth Kool:** Conceptualization, Methodology, Formal Analysis, Investigation, Writing – Review and editing **Beth Murray-Davis:** Writing – Review and editing **Billie Hunter:** Writing – Review and editing

Ethical approval

The Ethics Review Board of the University Medical Center Groningen (nr. 2023/062) approved this research.

Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this work, the author(s) used [Grammarly] to improve grammar and readability of the manuscript. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

We recognise the midwives who took part in our research.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2025.102122.

References

[1] 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.
[2] C. Catling, C. Rossiter, Midwifery workplace culture in Australia: a national survey of midwives, Women Birth 33 (5) (2020) 464–472.
[3] K. Stoll, J. Gallagher, A survey of burnout and intentions to leave the profession among Western Canadian midwives, Women Birth 32 (4) (2019) e441–e449.
[4] K. Harvie, M. Sidebotham, J. Fenwick, Australian midwives' intentions to leave the profession and the reasons why, Women Birth 32 (6) (2019) e584–e593.
[5] M. Takase, A concept analysis of turnover intention: Implications for nursing management, Collegian 17 (1) (2010) 3–12.
[6] L. Kool, E.I. Feijen-de Jong, N.J. Mastenbroek, F.G. Schellevis, D.A. Jaarsma, Midwives' occupational wellbeing and its determinants. A cross-sectional study among newly qualified and experienced Dutch midwives, Midwifery 125 (2023) 103776.
[7] J. Cull, B. Hunter, J. Henley, J. Fenwick, M. Sidebotham, Overwhelmed and out of my depth": responses from early career midwives in the United Kingdom to the work, health and emotional lives of midwives study, Women Birth 33 (6) (2020) e549–e557.
[8] V. Vaičienė, A. Blaževičienė, J. Macijauskiene, M. Sidebotham, The prevalence of burnout, depression, anxiety and stress in the Lithuanian midwifery workforce and correlation with sociodemographic factors, Nurs. Open 9 (4) (2022) 2209–2216.
[9] L. Butska, K. Stoll, When midwives burn out: differences in the experiences of midwives in British Columbia and Alberta, Can. J. Midwifery Res. Pract. 19 (1) (2020).
[10] B. Hunter, J. Segrott, Renegotiating inter-professional boundaries in maternity care: implementing a clinical pathway for normal labour, Socio Health Illn. 36 (5) (2014) 719–737. /06/01.
[11] T. Zhang, J. Feng, H. Jiang, X. Shen, B. Pu, Y. Gan, Association of professional identity, job satisfaction and burnout with turnover intention among general practitioners in China: evidence from a national survey, BMC Health Serv. Res. 21 (2021) 1–11.
[12] T.L. Mharapara, N. Staniland, M. Stadler, J.H. Clemons, L. Dixon, Drivers of job satisfaction in midwifery—A work design approach, Women Birth 35 (4) (2022) e348–e355.
[13] M. Cornett, C. Palermo, S. Ash, Professional identity research in the health professions—a scoping review, Adv. Health Sci. Educ. 28 (2) (2023) 589–642.
[14] S. Best, S. Williams, Professional identity in interprofessional teams: findings from a scoping review, J. Interprof. care 33 (2) (2019) 170–181.
[15] K.A. McNeil, R.J. Mitchell, V. Parker, Interprofessional practice and professional identity threat, Health Sociol. Rev. 22 (3) (2013) 291–307.
[16] Y. Fontein-Kuipers, H. den Hartog-van Veen, L. Klop, L. Zondag, Conflicting values experienced by Dutch midwives: dilemmas of loyalty, responsibility and selfhood, Clin. Res. Obstet. Gynecol. 1 (1) (2018) 1–12.
[17] B. Hunter, Conflicting ideologies as a source of emotion work in midwifery, Midwifery 20 (3) (2004) 261–272.
[18] International Confederation of Midwives. Professional Framework for Midwifery. 2024.
[19] M.J. Renfrew, A. McFadden, M.H. Bastos, J. Campbell, A.A. Channon, N.F. Cheung, et al., Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care, Lancet 384 (9948) (2014) 1129–1145.
[20] KNOV. Meerjarenplan 2021-2025 KNOV. 2024.
[21] C. Erlingsson, P. Brysiewicz, A hands-on guide to doing content analysis, Afr. J. Emerg. Med. 7 (3) (2017) 93–99.

[22] B. Saunders, J. Sim, T. Kingstone, S. Baker, J. Waterfield, B. Bartlam, et al., Saturation in qualitative research: exploring its conceptualization and operationalization, Qual. Quant. 52 (2018) 1893–1907.
[23] Z. Bradfield, M. Kelly, Y. Hauck, R. Duggan, Midwives 'with woman'in the private obstetric model: Where divergent philosophies meet, Women Birth 32 (2) (2019) 157–167.
[24] E. Cramer, B. Hunter, Relationships between working conditions and emotional wellbeing in midwives, Women Birth 32 (6) (2019) 521–532.
[25] C. Feeley, Skilled heartfelt midwifery practice: safe. Relational Care for Alternative Physiological Births, Springer Nature, 2023.
[26] M. Hollander, E. de Miranda, F. Vandenbussche, J. van Dillen, L. Holten, Addressing a need. Holistic midwifery in the Netherlands: A qualitative analysis, PLoS One 14 (7) (2019) e0220489.
[27] S. Halldorsdottir, S.I. Karlsdottir, The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery, Scand. J. Caring Sci. 25 (4) (2011) 806–817.
[28] M. Crepinsek, R. Bell, I. Graham, R. Coutts, A global review of the inferred meaning of woman centred care within midwifery professional standards, Women Birth 36 (1) (2023) e99–e105.
[29] S. Viertiö, O. Kiviruusu, M. Piirtola, J. Kaprio, T. Korhonen, M. Marttunen, et al., Factors contributing to psychological distress in the working population, with a special reference to gender difference, BMC Public Health 21 (2021) 1–17.
[30] A. Rao, V.T. Shailashri, Work-Life balance of women medical professionals in the healthcare Sector-A systematic literature review, Int. J. Health Sci. Pharm. 5 (2) (2021) 54–79.
[31] A.M. Alobaid, C.M. Gosling, E. Khasawneh, L. McKenna, B. Williams, Challenges faced by female healthcare professionals in the workforce: a scoping review, J. Multidiscip. Healthc. 13 (2020) 681–691.
[32] J. Walsh, Gender, the work-life interface and wellbeing: a study of hospital doctors, Gend. Work Organ. 20 (4) (2013) 439–453.
[33] K. Teoh, J. Hassard, Linking Organisational Factors and Patient Care: Does Healthcare Workers' Well-being Matter? in: A. Montgomery, M. van der Doef, E. Panagopoulou, M.P. Leiter (Eds.), Connecting Healthcare Worker Well-Being, Patient Safety and Organisational Change. Aligning Perspectives on Health, Safety and Well-Being Springer Nature, Switzerland, 2020.
[34] Farag A.A. Multigenerational nursing workforce value differences and work environment: impact on RNs' turnover intentions. Doctoral dissertation, Case Western Reserve University. 2008.