

Conflicting Values experienced by Dutch Midwives – Dilemmas of Loyalty, Responsibility and Selfhood

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ABSTRACT

Objective: The objective of the study was to explore the dilemma's, the conflicting values, and their underlying factors that Dutch midwives experience when they find it difficult to conform to, or to accommodate women's care needs. **Methods:** Qualitative data were collected from 11 community-based midwives using narrative inquiry. **Findings:** Three themes emerged: (1) *Loyalty* - the conflict between wanting to be loyal to the woman's wishes and expectations AND to guidelines, scientific evidence and to the collaborative relationships with other professionals – the value of women's childbirth experiences *versus* the value of good health outcomes (influenced by the midwife's risk perception, the healthcare system and organization of care). (2) *Responsibility* - the conflict between respecting the woman AND doing her justice as a person and the social norm in maternity services - women's autonomy and individuality *versus* the midwife's accountability and responsibility (influenced by fear and wanting to "do good"). (3) *Selfhood* - the conflict between the woman's self-assertive behavior in pursuing her needs AND the midwife's professional behavior - the woman as self-expert *versus* the midwife's professional identity (influenced by control, experience, knowledge, and contextual issues). **Conclusion:** Midwives encounter women and colleagues whose wishes and norms lead to dilemmas and conflicts they need to manage in everyday practice. Education and supervision should involve the discussion and questioning of values.

Key words: conflicting values, midwifery, narratives, reflection

INTRODUCTION

The collaborative relationship between the woman and the midwife is the crux in midwifery care. The dynamics of this relationship, i.e., communication and interaction, are affected by the personal and professional values of the midwife.^[1,2]

Values are person's existential standards that define personal, professional, group, and social behavior and affect individual attitudes and moral.^[3-7] Professional midwifery values are the accepted norms by a midwife and/or a group or organization of midwives that are associated with the responsibilities and trust that society assigns to the midwifery profession.^[3,8-10] Professional values shape the midwife's identity, principles

and beliefs, decisions, consideration of consequences, and clinical judgment.^[11] Midwives values derive from history, education, and traditions.^[6,7] These values are embedded within the professional code of ethics,^[12-15] which aims to create a professional culture that supports best practice and attempts to draw boundaries around what is deemed acceptable conduct. For example, the Dutch organization of midwives refers to values such as human dignity, autonomy, the trusting relationship between midwives and women and maintained professional knowledge.^[16] However, midwives' codes of ethics can be limited in content, can contradict with midwives' own ideology or their individual particular value system that they carry with them and can even differ from the value system of other professionals they have to collaborate with (e.g., obstetricians).^[15,17,18]

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Women nowadays have altered ideas and expectations about pregnancy and birth and about service quality of maternity services, compared to earlier generations of childbearing women.^[19-21] Care provision offered by midwives might not run parallel with the needs and wishes of current women.^[19,21] Midwives sometimes experience women's needs and wishes as demanding, occasionally on the verge of being boundless or unsafe, and sometimes difficult or challenging to answer to.^[22] Guidelines, risk perception, control appraisal, resources, and personal meaning and values, are appointed as factors which create dilemmas that affect concurrent care management for the midwife.^[22]

For midwives, it is important to "do good" or to be "a good midwife."^[9,15] To do so, midwives exercise their knowledge and skills while placing the woman at the center of care. Inherent responsibilities for the health and safety of women and children influence deciding what takes precedence, when confronted with wishes of women that interact or conflict with these responsibilities. Midwives will have to weigh and consider the different professional and personal values. These values can be conflicting, causing internal debates and withdrawal or decreased service quality.^[5,7,23,24]

Little is known about which values are considered by midwives before they decide to conform to, to accommodate, or to decline or deviate from women's wishes and needs.^[24] It is unknown how these internal thought processes occur; which exact dilemmas arise and which factors attribute to those dilemmas. To understand the meaning of this complex subjective phenomenon that belongs to the midwifery profession, we aimed to explore the conflicting values and underlying factors that midwife experience when they find it difficult to conform to, or to accommodate women's care needs. An internal dilemma in this study is regarded as a personally experienced case of dissonance between values that had compelled the midwife during practice - prompting a process of critical thinking and personal exploration, leading to a course of action, sometimes affecting pursuing the (morally) right course of action.^[24-26] This study does not focus on the conflict between the woman's values and those of the midwife. Instead, this study is an attempt to identify and understand the internal debate and thought processes of midwives. It examines the detailed experience of personally experienced dilemmas involving conflicting values, triggered by practice events in which the woman is directly or indirectly involved - to better engage midwives in (reflective) practice.

METHODS

Design

We performed a qualitative study utilizing a narrative inquiry methodology.

Procedure and participants

To recruit participants, we used purposive mixed-sampling techniques. We approached midwifery practices by email using the clinical placement record for midwifery students from our faculty of midwifery education; through the authors' midwifery networks; and by posting a recruiting message on our school of midwifery's Facebook page. Qualified community-based midwives providing midwife-led care in the Netherlands who had been practicing midwifery for at least the past 12 months (full or part-time) were eligible for the study. Hospital-based midwives were excluded from the study. We recruited midwives from various Dutch regions, across different age groups, with a variety of years of work experience in the community and with religious and non-religious backgrounds; as these aspects seem to be of influence to midwives' values.^[22] 18 midwives expressed their interest. 11 midwives were included in the study; seven midwives could not be scheduled for an interview due to not being able to find a date that suited both the participant and the researchers. The interviewers (HdH and LK) were unfamiliar with the participants before the interviews, assuming the limitation to gratitude bias.^[27] The participants were informed that they could freely withdraw from the study at any time.

The interviewers were final-year midwifery students. They had received training about interview techniques and had conducted a literature review about midwives' conflicting values before the study. In preparation to the data collection, the first author interviewed the researchers about their personally experienced case of dissonance between values that had compelled them during practice. The outcome of this process had a dual function: (1) Didactic: first-hand experience of the used data collection procedure as a mechanism of learning and (2) to increase awareness of the interviewers' potential biases and judgmental attitudes; to minimize influencing participants' answers or cause research bias and to minimize the likelihood of observant-expectancy bias.^[27,28] This course of action was critical in allowing the students to become more effective interviewers.^[29]

The Rotterdam Research Ethics Committee confirmed that, because of the non-invasive character of the study, ethical approval was not required. We conformed to the ethical principles of the Central Committee on Research Involving Human Subject.^[30] We obtained written consent from all the participants in our study.

Data collection through narrative interviewing

Data were collected through in-depth face-to-face narrative interviewing being of value for collecting personal stories about individual experiences of certain events. We expected that by the use of narrative interviewing, we were more able to reconstruct participants' lived experiences,

Table 1: Application of phases of the narrative interview according to Jovchelovitch and Bauer

Phases	Rules
Preparation	Exploring the field to understand the topic of study - literature review before the study Formulating research question - to explore the conflicting values and underlying factors that midwife experience when they find it difficult to conform to women's care needs
1. Initialization	Formulating topic for narration: "I'm collecting stories about dilemmas you might have experienced during practice - situations you did not feel comfortable with or caused friction or conflict within yourself - because wishes of a woman contradicted with your values as a midwife. Please, could you tell me your story? Take your time. Everything you tell me will be valuable for my research; there are no wrong stories or answers. We've got as much time as you need for this. I'll listen first, I won't interrupt and I may take a couple of notes that I'll ask you questions about later. So, can you please tell me everything you remember about the event and about the experiences that were important to you." Alternative scenarios - eight practice-based alternative scenarios were drawn up by the authors (to be presented in case the participant did not come up with a first-hand experience): 1. Refusal artificial rupture of membranes to augment labor; 2. uninformed demand for pain relief; 3. episiotomy on demand; 4. lotus birth/umbilical non-severance; 5. request homebirth against medical advice/guidelines; 6. refusal of referral when this is necessary; 7. re-infubulation after childbirth; 8. patronising behavior of another practitioner in the presence of the woman*
2. Main narration	Uninterrupted story-telling Non-verbal signs of attentive listening Explicit encouragement to continue narration Occasional note-taking for later questioning Wait for signals to end the storytelling - "coda"
3. Questioning phase	No why questions No opinion and attitude questions No arguing or pointing out contradictions Only refer to events mentioned in the story and to topics of the topic of study - an opportunity for further recall "You said(...) can you please tell me a little bit more about it?"
4. Concluding talk	Why questions now allowed (for interpretation of the data): "Why did it matter to you," "Why was it important to you?" "Why was it difficult for you?" "Why did it bother you?" "Why did it make you feel uncomfortable?" "Why were you happy or pleased?" "Why did it make you think?" "Why do you think it was wrong/improper/unethical?" Memory-protocol immediately after the interview. Related to the topics synthesized from the literature: Ideology/(salient) beliefs/professional identity/professional competency/professional socialization/religion/education ^[4,10,34] to fuse relevance structures (interpretation themes)

*Based on most identified dilemmas in practice – identified in a survey among 46 final-year student midwives prior to the study

their thoughts, and actions.^[31,32] We used the structure of narrative interviewing as a guide to design the interviews, as described by Jovchelovitch and Bauer^[33] [Table 1]. We conducted a pilot-interview for comprehensibility and clarity of the instructions and "why questions" being utilized. The findings and feedback from the pilot-interview were evaluated by the authors; no changes were made to the study approach.

The interviews were conducted in March 2016 at a time and place that were convenient for the participants. The interviews lasted between 60 and 80 min. Participants were instructed for narration, and they were invited to reveal anything they wanted to say [Table 1]. The interviews were audiotaped and

consent for audiotaping was obtained before the interview. The participants were assured of confidentiality and anonymity. Participants' responses to the "why questions" were described immediately after the interview - in a so-called memory-protocol [Table 1], using keywords.

Data analysis

The recorded interviews were described verbatim, and the memory-protocols were added to the transcripts, aiding the interpretation of the recorded data.^[27,33,35] We anonymized the transcripts. As a reliability check, we read the transcripts several times to get a sense of the content as a whole.^[28,36] To generalize and condensate meaning, we applied a stepwise procedure of qualitative text reduction. We applied three

rounds of serial phrasing per individual interview (phrasing text segments, paraphrasing passages, and summary sentences).^[37] Then, codes were developed for each interview, which was later collated into coherent categories. We achieved saturation on all categories. At this stage, we discussed the memory-protocols to scaffold the structure of reasoning and of contextual comprehension - so-called relevance structuring.^[37] We then defined the themes. We shared and discussed findings and meaning throughout by means of an iterative process of constant comparing and contrasting.^[28,33,36] The trail of our analysis is shown in Table 2.

Rigor

The transcripts of the narration were emailed to the participants, giving them an opportunity to change or remove any data. One participant responded, resulting in rectification of the transcript, enhancing trustworthiness of the analysis.^[27,28,36] All used strategies were documented and to enhance the credibility of our findings, the final themes were discussed with researchers and midwifery lecturers of our faculty.^[37] The writing of this paper was guided by the consolidated criteria for reporting qualitative research.^[38]

RESULTS

The 11 midwives in our study practiced in the north, central, and south/west regions of the Netherlands with variation in the level of urbanization. They had an average age of 37 (22–59) years and on average 13 (1–28) years of working experience. All narratives were first-hand, thus personal experiences. The alternatives scenarios for narration, presented in Table 1, were not consulted by the participants for narration. The topics of participants' stories of experienced dilemmas are presented in Box 1. Three themes emerged from the data that described the case of dissonance, i.e., dilemma, that the

participants experienced, the conflicting values contributing to the participant's internal conflict, i.e., dilemma and the underlying factors. Figures present the dilemma's/conflicts, values and the underlying factors. Quotes (phrases) illustrate the findings [also shown in Table 2].

Loyalty

The first theme describes the midwife's experienced dilemma effectuating from simultaneously wanting to be loyal to the woman's needs, consisting of her wishes and expectations to achieve or accommodate optimal experiences and to be loyal to guidelines, evidence, and collaborative relationships with other professionals. The midwife values the woman's personal satisfying childbirth and positive care experiences versus the value of good health outcomes and safety, i.e., prevention of interventions, morbidity, and mortality. These values are influenced by the midwife's underlying perceptions of risk, perception of the impact of pregnancy and birth on mother and child, the maternity health-care system and perceptions of the organization of maternity care services [Table 2 and Figure 1].

“On one hand, there was this feeling of (...) to be “good” to her, meeting her wishes, her needs. That's what I tried. To do what she liked, wanted, needed (...) Giving her the best and most beautiful experience ever. It will be part of the rest of her life”

“Guidelines are there for a reason (...) for the prevention of morbidity and mortality. When it becomes life threatening for mother or for the baby, acute and dangerous (...) I stick to the guidelines”

“I really find it difficult to deviate from the protocols we have agreed to in our area, with the local hospital”

Box 1: Topics of narratives described by participants. Some topics were described in the same narrative

- A woman's refusal of induction of labor at post-term gestation by means of Oxytocin IV;
- A woman's request for at home artificial rupture of membranes (AROM) at post-term gestation;
- A woman's refusal for AROM as method of induction at post-term gestation;
- A woman's refusal for referral for prolonged rupture of membranes (>48 h);
- A woman's wish for the dog to be present at the birth;
- A woman's refusal for referral for induction;
- A woman's decision to have an unattended birth;
- A woman's request for a homebirth with a history of postpartum haemorrhage (PPH);
- A woman's preference for a specific midwife in the group practice;
- A woman's refusal for active management of the third stage of labor;
- A woman's refusal for internal examination during labor;
- A woman's refusal to undertake a glucose tolerance test;
- A women's refusal for other health professionals present at the birth other than the midwife;
- The midwife being found negligent by the woman.

Table 2: Examples of analysis trail and quotes illustrating the themes

Phrasing (text segments) and paraphrasing	Summary sentence	Code (keywords)	Category	Memory-protocol	Theme (dilemma)
<p>On the one hand, there was this feeling of... wanting... yes to be "good" to her, <i>meeting her wishes, her needs</i>. That's what I tried. <i>To do what she liked, wanted, needed</i> you know. Giving her the best and most beautiful experience ever. Because I know, uh, I was able to do that, I was right there and then, <i>to contribute to her experience</i>, making it a good one. It will be part of the rest of her life. <i>That is important</i> you know, or at least, that's what I think</p> <p>I said to her: "I know what you want and I really would like to help you, but <i>we have an agreement with the hospital</i>". I really find it difficult to deviate from the protocols we have agreed to in our area, <i>with the local hospital, the obstetricians, and other midwives</i>. We have an agreement. <i>We have agreed on the rules</i>, so better stick to them to keep everyone happy</p> <p>She wanted to give birth at home after 42 weeks. In the bath, no Syntocinon while she hemorrhaged the previous birth. No maternity care assistant being present at the birth, but <i>that's what we do here, how it's organized</i>. She did not want to go for a postdate check in the hospital. <i>I am responsible for the normal, for physiology - that's what we do as midwives</i>. <i>When things deviate from the norm, I have to deal with emergencies</i>. We have to prevent unnecessary ones, the avoidable ones. <i>I am the one that needs to refer her to hospital, to obstetric care</i>. That's what I told her. Guiding and safeguarding <i>normality, that's my scope of practice</i>, that's what I am trained to do</p> <p><i>Guidelines are there for a reason, based on evidence about interventions and the prevention of morbidity and mortality. When it becomes life threatening for mother or for the baby, acute and dangerous, well, yes, I stick to the guidelines</i>. Sticking to the guidelines than outweighs everything else, even the woman's wishes. I have the audits at the back of my mind</p>	<p>Women's wishes and expectations of pregnancy and childbirth are important to the midwife and she knows she plays a role in contributing to a good and meaningful (life) experience</p> <p>The midwife wants to adhere to agreements that have been made with other health-care practitioners on local level/day-to-day collaborative practice</p> <p>The midwife is aware of her role, place, and scope of practice within the maternity care system and its organization</p> <p>Midwife's perceptions of the use of guidelines and protocols with regard to achieving good outcomes and risk management</p>	<p>Importance of women's wishes and expectations</p> <p>Being involved in collaborative relationships</p> <p>Agreements with colleagues</p> <p>Role in the organization of maternity care services</p> <p>Midwife's scope</p> <p>Perinatal outcomes</p> <p>Risk management according to guidelines</p> <p>Non-maleficence</p>	<p>Fidelity to women's needs</p> <p>Fidelity to colleagues</p> <p>Considering maternity health-care organization</p> <p>Considering health outcomes</p>	<p>Solidarity to women's needs</p> <p>Freedom of choice</p> <p>Solidarity to colleagues</p> <p>Solidarity to health system</p> <p>Perceived authority of others</p> <p>Solidarity to health system</p> <p>Solidarity to psychological thinking/ approach</p> <p>Governance</p>	<p>LOYALTY</p>

(Contd...)

Table 2: (Continued)

Phrasing (text segments) and paraphrasing	Summary sentence	Code (keywords)	Category	Memory-protocol	Theme (dilemma)
Um... I think it is very...very important that (name woman) had partly, no... actually, <i>as much as possible, that she had control over her pregnancy and birth, felt in control really.</i> She questioned us about a lot of things; she didn't take things for granted, good for her. Scheduling her own cesarean.... (laughs) well that provided her sense of control. I said: "good on you, take control girl!" <i>Making that possible for her, it made her happy.</i> I wanted to do that for her, I knew it would do her good, please her, be compassionate, be good to her. <i>I wanted to give her good quality of care, be a good midwife, use my knowledge and skills, providing safe care</i>	The midwife acknowledges the importance and meaning for the woman of being in control during the childbirth process and respects this	Taking control and giving control	Respect for autonomy	Being authentic Divine authority	RESPONSIBILITY
With fear I mean, well, um, fear for what other care professionals think of me, specifically those in the hospital or maybe, well, even my colleagues in the practice. What happens when I conform to her (name woman) wish when, if, you know, something would go wrong. Moreover, um, it could happen you know while you know that if you would not have done that what she wanted you to do. Um, what I feel is well fear, fear for others, for colleagues, obstetricians, yes, <i>anxious about what they might think about me, that I am irresponsible.</i> I do need them for other things, I don't want to do things that jeopardize our collaboration or relationship	The midwife's need for being a good midwife for the woman providing quality of care	Being good Quality of care	Beneficence	Moral good Absolute duty	
She (woman) blamed me for sticking to the protocol. That was a year and a half later. Remember (refers to a court procedure) that made me think. <i>I am aware that I refer earlier then I used to, make more notes, things like that, just in case someone thinks I am liable for negligence, scary. Thinking: "Will she put in a complaint?"</i> Once you have that experience, it'll haunt you, you're more uh cautious	To midwife's need to be regarded as a responsible practitioner by colleagues	Responsibility Team member	To be a responsible colleague	Feelings of obligation	
	Fear for litigation	Defensive clinical practice Litigation	Accountability	Duty to act	

(Contd...)

Table 2: (Continued)

Phrasing (text segments) and paraphrasing	Summary sentence	Code (keywords)	Category	Memory-protocol	Theme (dilemma)
Because I think that <i>in my position as "the expert," "the professional," I ultimately know best</i> , I know when the situation is safe. I determine what the boundaries are. I know where to draw the line between safe and unsafe. If it is risky to stay at home, we will transfer to hospital	The midwife's perception of her experience, knowledge, organization/infrastructure of maternity services and professional remit	Professional attributes	The midwife as professional	Dominance of autonomy	SELFHOOD
My intuition plays a role in my decision making, <i>it's important for me as a person</i>	Importance of perception of the midwife's personal attributes	Personal attributes	The midwife as a person	Self-respect	
What I think is important, safe, smart, the best thing to do... at the end of the day it is just an opinion. But so is hers. She has opinions based of her own, <i>on her previous experiences, she knows how her body functions, what works for her and what doesn't</i>	Woman's own knowledge and experience as reference	Experiential knowledge Previous experiences	The woman as expert	Individual autonomy Respecting others	
She (<i>woman</i>) was quite airy-fairy... esoteric in a way, very set in her ways. Certain things that were important to her. No scans for example... The birth plan was full of, uh, alternative things, doable but, uh, well, different. <i>Choices that concerned her, herself... um, she was completely entitled to do that...</i> it concerned her. It was her experience, her life-event, her birth... yeah. At the end of the day, <i>we respected it. Everybody is different, yeah...</i> this is, yes, a huge part of her own life, not mine. Definitely, yes	The midwife is aware of the importance and right of women to make individual choices and decisions that suit the woman and her situation	Respecting women's individual choices	The woman as an individual	Respecting others Individual autonomy Independence	
<i>She is a diabetics, a multigravid woman, uninsured, on her own.</i> We know her from previous pregnancies. When she is pregnant <i>she keeps her diet, checks her own glucose levels.</i> She is a <i>clever woman, well-organized, nice woman</i> too, well-behaved children, too bad her finances are limited and her husband walked out.	The perception of multiple factors such as personality, personal situation, and coping	Personality of woman Context of the woman's situation	Personality in context	Respecting others Independence	
She (<i>woman</i>) literally slammed her fist on the table; she did not want that GTT. Then, who am I? Forcing her? <i>There is so much as self-determination, self-management. Moreover, sometimes it's the other way around. I say what to do and she complies, no discussion, no questions.</i>	Self-determination and self-management do parallel exist next to compliance and influence level of control of both woman and midwife	Assertiveness and compliance Sense of control	Perceived self-control	Locus of control	

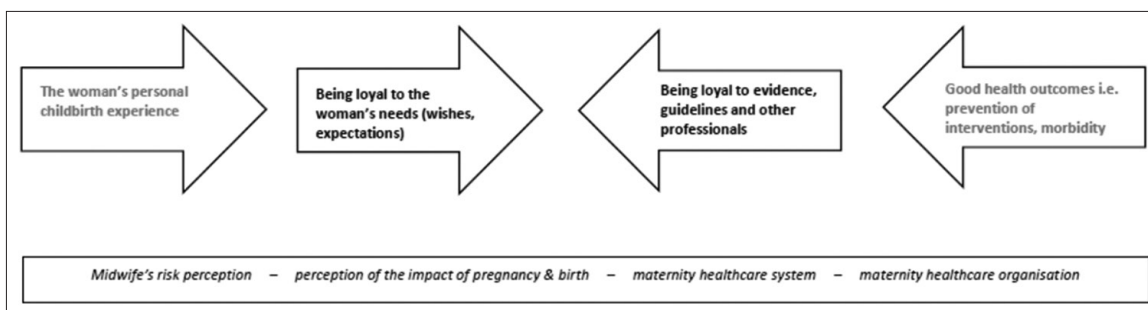


Figure 1: Loyalty: Dilemma, values, and underlying factors

Responsibility

This theme describes the dilemma that the midwife experiences when it needs to be determined who is responsible and accountable for choices, decisions, and actions during the care process. The dilemma originates from simultaneously feeling responsible for doing the woman justice as an individual, being honest, and “being good” to her and to be regarded as a responsible and trustworthy professional by colleagues. The midwife values the woman’s rights, her autonomy and the woman’s individuality versus the values that are integrated into the code of conduct such as professional responsibility and accountability and quality of practice. The midwife values are influenced by the underlying need to “be a good midwife,” by professional social norms and the apprehension for consequences of actions, including litigation - the latter is influenced by fear [Table 2 and Figure 2].

“It is very...very important that she (woman) (...) had control over her pregnancy and birth (...) “take control girl”

“I wanted to give her good quality of care, be a good midwife (...) providing safe care”

“With fear I mean (...) fear for what other care professionals think of me”

“Just in case (...) I am found liable for negligence, scary. Thinking: Will she put in a complaint?”

Selfhood

The third theme describes the midwife’s dilemma caused by a conflict between the woman’s and the midwife’s levels of assertiveness or compliance. This conflict asserts itself in the dissonance between the midwife’s perception of the woman’s assertiveness in expressing her needs and her levels of persistence and insistence, opposed to compliance, to pursuit her needs on one side. On the other side, the midwife’s need for perseverance in adhering to everything that defines her professional remit - defining and determining the woman’s and the midwife’s respective selfhoods and self-manifestation. The midwife’s values the woman’s experiential knowledge and self-management and self-determination in care versus her own professional identity. These values are influenced by

perceived control, control appraisal, professional experience and knowledge, logistics and the midwife’s perception of her professional scope of practice and personal satisfaction, but also how she perceives the woman’s personality or characteristics or context, i.e., circumstances [Table 2 and Figure 3].

“She (woman) slammed her fist on the table, she did not want that GTT. Then, who am I?”

“She (woman) was completely entitled to do that”

“She knows how her body functions, what works for her”

“I think that in my position as “the expert,” “the professional,” I ultimately know best”

“I say what to do and she (woman) complies, no discussion, no questions”

To provide a summary from the memory-protocols, we added the keywords that emerged in Box 2. We included the participants’ responses regarding the notion of reflection to the memory-protocols as all of the participants strongly voiced the value of sharing their individual dilemma experiences. As illustrated by the quote, during narration the participants became aware that they hardly think of value conflicts as a self-reflection topic. This in itself was appointed by the authors as an additional but meaningful observation.

“I am never really that much aware Into such depth ... of the reasons why I sometimes experience these dilemma’s and why I respond to them in the way I do (...) Re-telling those moments help me to reflect and clarify my feelings and actions... wow, I should do this more often”

DISCUSSION AND CONCLUSION

Discussion

To the best of our knowledge, this is the first study that focuses on midwives’ experiences of value conflicts. This study gives us a more complete view of the factors driving the internal thought processes of midwives when experiencing dilemmas; the values they consider and which factors attribute to those

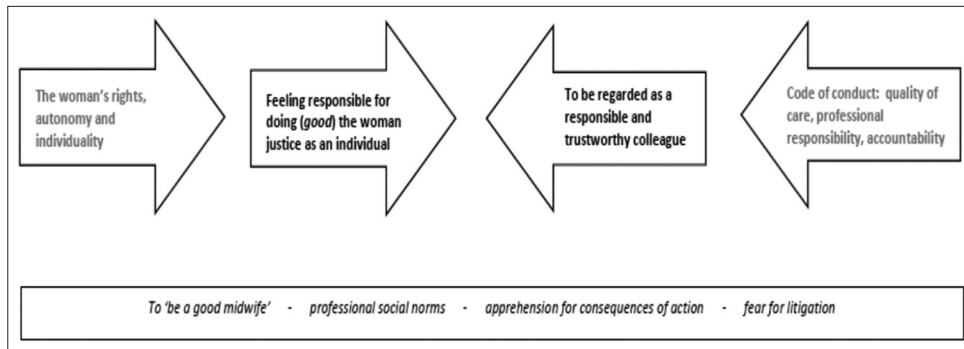


Figure 2: Responsibility: **Dilemma**, **values**, and *underlying factors*

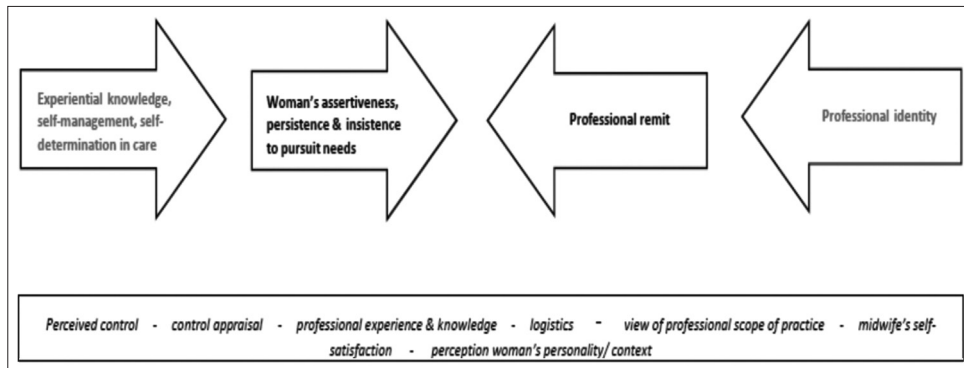


Figure 3: Selfhood: **Dilemma**, **values**, and *underlying factors*

Box 2: Keywords emerging from the memory protocols

Notion of autonomy - Individual autonomy - Dominance of autonomy - Solidarity to the self - Solidarity to colleagues - Solidarity to health system - Solidarity to the woman - **Independence** - Freedom of choice - Moral wisdom - Moral good - Moralness - Personal integrity - Breaches of dignity - Principlism - Habituation - Feelings of obligation - Absolute duty - **Respecting others** - **Self-respect** - Value of life - Duty to act - Breaches of safety - Divine authority - Societal expectations - Perceived authority of others - Perceived control of others - **Locus of control** - Governance - Altruism - Solidarity to physiological thinking/ approach - Being authentic
Being the guardian of normality

Notions of reflection*
 Re-contextualization - Recounting -
 Re-telling - Debriefing - Reinterpretation -
 Emotional clarification - Self-awareness -
 Self-evaluation - Moral reflection

Loyalty (underlined)
Responsibility (italic)
Selfhood (bold)
 *Additional observations voiced by the participants

values. Theoretically, conflicting values rest on personal norms and on professional accepted norms and standards in midwifery practice and organization.^[24] In our study, we found these pillars to play a role in all themes.

A way of understanding the findings of “loyalty” might be that the midwives in our study moved between two different belief systems: A biomedical model which is reliant on evidence and knowledge, and a humanistic and holistic model which values physical and psychosocial well-being of women.^[35] Nowadays,

midwives seem to move between the biomedical aspects of care while trying to be sensitive to women’s needs but there can be a struggle between the two models as the midwives learn to accommodate opposing belief systems.^[39] From our analysis, it became obvious that this experience caused dilemmas for our participants that contribute to their personal decision threshold as professionals. The theme “loyalty” also showed the strong endorsement of the midwives with regard to the importance of a good collaboration with colleagues and the influence of the organization of maternity care, consistent with factors that are

associated with clinical decision-making.^[40] In our study, the midwife's experienced social norm seemed to play a profound role. We observed that midwives struggled with inter- and intra-professional tension in their collaborations with other midwives and obstetricians. It seemed that good collaboration with direct colleagues is considered as an important factor to be regarded as a "good" midwife by the midwifery society, i.e., culture, and to be of main influence to comply with cultural norms.^[9] We found midwives' responses in our study to be those of compliance, instead of resistance or initiating a critical dialogue with colleagues.^[39,40]

The theme "responsibility" seemed to be connected to the notion of professional authenticity. Our findings agreed with earlier research that midwives experience a discrepancy between "doing good" and "being a good midwife".^[9,15] On the one hand, midwives want "to be with" and "to work for" women and to support a woman to make the right choices. On the other hand, they want to adhere to their professional remit and identity by adopting and internalizing the values and norms of the midwifery profession for professional socialization.^[9,15] Our findings suggested that the midwives in our study might hold certain profound virtues about themselves - illustrated in Box 2. While maintaining that they wished to provide women-centered care, there was a simultaneous acceptance of power dynamics, medical protocols, and technology - affecting the midwife's autonomy and identity, even impeding role authentically.^[39]

All codes and categories that are included in the theme "selfhood" align with the model of woman-centered care where a balance is sought between the woman - as an individual human being - and the midwife - as an individual and professional - shaped through recognizing and respecting one another's respective fields of expertise.^[41] "Selfhood" reflected a tension within the requirements of professionalism which requires collaboration with women and shared-decision making. While midwives appear to support this approach,^[42] the accounts of our participants indicated that this was not always easy to enact on in practice. Daemers *et al.*^[40] described that midwives tend to hand over control to other maternity care professionals. The theme "selfhood," however, showed that midwives in our study merely indicated handing over control to the woman. Although our participants tended handing over control to women when a dilemma arose, they did experience control issues while doing this. Our findings therefore, do not completely resonate with the fact that the decisions made by midwives in general adhere to policies and protocols rather than negotiated with women.^[43] The memory protocols showed that "selfhood" was strongly related to the autonomy of the midwife (Box 2). Tension in deciding if control is assigned to policies, or to the woman, raises the question of how autonomous a midwife in reality is, or if autonomy has still not evolved from its paternalistic roots.^[44] When autonomy is regarded as a principle of midwifery care, it seems to create tension between the midwife's course of action and the woman's choices.

Autonomy in our study, therefore, seemed to have shifted from consideration of individualism to the recognition of being part of a relational system in which women, midwives, and other maternity care practitioners position themselves - more closely fitting post-structuralist understandings of autonomy.^[44] Founding midwifery practice on the belief that individuals are autonomous and that health-care professionals' practice should reflect the principles of ethics^[45] is consistent with the theme "selfhood" in our study. In a world of diversity and complexity, it is essential to walk carefully, to be attentive to the values and beliefs of others - women or colleagues - in a word, to be respectful of the "otherness" of others.

The themes "loyalty" and "responsibility" included codes and categories (fidelity, non-maleficence, respect for autonomy, and beneficence) that align with ethical dilemmas,^[11] suggesting some overlap between these themes. The topics of the narratives in our study (Box 1), however, merely included practical day-to-day occurring issues with a more basic character. Most of the individual experiences included situations where women refused certain interventions. We presume that various levels or categories of conflicts exist in midwifery practice, ranging from more obvious or ordinary concerns and value conflicts opposed to extraordinary, complex, and idiosyncratic concerns. We do not know to what level or category the topics narrated in our study belong to, as this might be very individual, depending on years of experience and education.^[18] Grappling with value conflicts can be at an almost banal level. At other times, the issues will be more complex or more universal. Hence, the unborn child has not been mentioned by our participants, i.e., to be loyal to or to be responsible for; whether midwives think they have to protect the interests of the (unborn) baby. This is an issue that might require more attention in value conflicts focused research.^[46]

A number of limitations are apparent in this study and may, therefore, affect the usability of its findings. The first is that the participants were all from the Netherlands and the stories they told were shared within the context of the Dutch maternity system. Moreover, this was a study of 11 midwives working in primary care, thus our results hold limited transferability. However, as with all qualitative research, our goal was not statistical representation, but a rich understanding of the thought processes of our participants. Self-selection may have unintentionally led to a sample bias,^[28,34] as those who might have conformed and changed their values may not have wished to take part in the study. The experiences of conflict may also have been too painful for some to share for the purpose of research. It could be that we have not included these midwives in our study. Maybe we have now presented reports that only give us a scant account of the reality. It is inevitable that the researchers' values had some effect on the research that we have undertaken,^[33] and this can be at any or all stages of the research. In as much as it can be regarded as a limitation, the being as "student midwife researcher" can also be seen as an advantage

to the study. It is possible that the participants felt a shared empathy, as "one of them" and this might have enabled them to talk freely about their experiences, knowing the interviewers would understand or not seeing the interviewers (i.e., students) as a threat. There is also no certainty that the perceptions and beliefs of the interviewers about midwifery are the same as those of the participants. This sense of belonging to the same profession may have led both researchers and participants to make incorrect assumptions, compounding biases.

Practical implications

The keywords in our memory-protocol (Box 2) reflected the midwives in our study as true reflective practitioners, although participants in our study confided that they hardly think of value conflicts as a self-reflection topic. This is valuable in itself as the interviews seemed to have been conversations which midwife felt able to make sense of and to take part in, at least in the sense of having a point of view on the concrete issues involved. Midwives who are faced with dilemmas in care are not always prepared for them and the understanding and various actions and responses. When having a true and lucid consciousness of the situation, storytelling can aid reflection. The first step in critical reflection lies in spotting where the dilemmas lie and identifying the issues raised. From an educational perspective, the findings suggest the importance of raising the awareness of values and their role in influencing the experience of midwifery practice.^[47] Value-conflicts seem to be about wrestling with the dilemma and search for "the right thing to do." This fact makes the importance of laying a sound foundation for reflection a compelling issue for midwifery education. Like any skill, it is only maintained by frequent practice. Education and supervision during practice should involve the discussion and questioning of values. It might be of interest to involve other maternity care professionals^[47] as these are often referred to be of influence to the outcomes of dilemmas. The midwife deliberately takes on the professional care of women and has a particular responsibility to be or become a reflective practitioner. Reflection, alone or with others, is an indispensable part of professional development and is deepened by deliberate exercises such as storytelling. Story telling is not new to midwifery; midwives' stories have already provided a way to disclose embedded meanings and values that reflect what midwives want to convey about themselves as professionals.^[48,49] Education and supervision during practice involving the discussion and questioning of values seems warranted to support reflective practice and professional development of the midwifery profession.

CONCLUSION

Midwives' value conflicts are to be found in simple and practical day-to-day issues, thus midwives will frequently encounter conflicts with the values held by themselves. It can be concluded that midwives struggle with inter- and intra-professional tension. Because conflicting values demand a

strong sense of midwifery authenticity, it is of importance to better understand the foundations of value conflicts in midwifery practice. More needs to be known about midwives' taxonomy of midwifery ideologies, what their personal ideological viewpoints are, the extent to which their views frame their behavior and conduct in professional context, and the basis on which they justify their professional conduct. Storytelling might be able to aid in this process.

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