Journal of Interprofessional Care

ISSN: 1356-1820 (Print) 1469-9567 (Online) Journal homepage: http://www.tandfonline.com/loi/ijic20

How the past influences interprofessional collaboration between obstetricians and midwives in the Netherlands: Findings from a secondary analysis

Nadine van der Lee, Erik W. Driessen & Fedde Scheele

To cite this article: Nadine van der Lee, Erik W. Driessen & Fedde Scheele (2016): How the past influences interprofessional collaboration between obstetricians and midwives in the Netherlands: Findings from a secondary analysis, Journal of Interprofessional Care, DOI: 10.3109/13561820.2015.1064876

To link to this article: http://dx.doi.org/10.3109/13561820.2015.1064876

Published online: 21 Jan 2016.

JOURNAL OF INTERPROFESSIONAL CARE
http://dx.doi.org/10.3109/13561820.2015.1064876

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

How the past influences interprofessional collaboration between obstetricians and midwives in the Netherlands: Findings from a secondary analysis

Nadine van der Lee[a], Erik W. Driessen[b], and Fedde Scheele[c]

[a]Department of Medical Education, OLVG Location West, Amsterdam, The Netherlands; [b]Department of Educational Development and Research, Faculty of Health, Medicine, and Life Sciences, Maastricht University, Maastricht, The Netherlands; [c]Department of Medical Education, VU University Medical Center, Amsterdam, The Netherlands

ABSTRACT

Collaborations between groups of professionals often have a long history, which can still influence contemporary practice. If problems in the collaboration occur, the search for effective interventions for these problems may be informed by analysing current practice as well as the historical development of the collaboration. The study focused on the collaboration between obstetricians and midwives in the Netherlands. We performed a secondary analysis of questionnaire data focusing on midwives evaluating the collaborative performance of obstetricians in the Netherlands. Template analysis was used to analyse the questionnaires. The initial template was based on a model for interprofessional collaboration. As a final step, we reflected on the results in light of the historical development of the collaboration. The midwives experienced a power imbalance and a lack of trust and mutual acquaintanceship in their collaboration with obstetricians. They also reported a need for interprofessional governance and formalization. Most of these reported problems in the collaboration have their origin in the historical development of both professions and in the development of the collaboration between both professional groups. Combining an exploration of contemporary interprofessional practice with a historical perspective on interprofessional collaboration is fruitful for understanding problems in collaboration between professional groups, and provides guidance for improving collaboration.

ARTICLE HISTORY
Received 23 May 2014
Revised 21 April 2015
Accepted 18 June 2015

KEYWORDS
Interprofessional collaboration; interprofessional teamwork; maternity care; midwives; obstetrics; questionnaires; secondary analysis

Introduction

Collaboration between groups of professionals often have a long history, which can still influence contemporary practice (Khalili, Hall, & Deluca, 2014; Price, Doucet, & Hall, 2014). If problems in the collaboration occur, the search for effective interventions for these problems may be informed by reflecting on the historical development as well as on contemporary practice of the collaboration. Yet, the historical perspective is often neglected (Macmillan & Reeves, 2014).

According to D'Amour, Goulet, Labadie, Martin-Rodriguez, & Pineault (2008), establishing effective collaboration entails the interplay of several elements within both the relational and organizational domains of the collaboration between the involved professionals. In their model for interprofessional collaboration, D'Amour et al. (2008) distinguished the elements "governance", "formalization", "shared goals and vision", and "internalization" to be key for effective collaboration.

In a previous study, we explored the historical development of the collaboration between obstetricians and midwives in Dutch maternity care (van der Lee et al., 2014). This historical perspective revealed that the development was rather unfavourable for the establishment of effective interprofessional collaboration. Problems were found within both the organizational and relational domains of collaboration. For example, we found that the interaction between the professions could be character as being competitive rather than collaborative (van der Lee et al., 2014). Both professions united in separate professional societies, developed and used unidisciplinary protocols, and strived to preserve autonomy in professional practice (Houtzager, 1993; Janssens, 1997; KNOV, 2009; NVOG, 2013). And although both professions shared the same patient population and pursued the same goal, i.e. good maternity care (De Vries, 2004), there was no evidence of "interprofessional governance" and "shared goals and vision".

Also, on the level of "formalization" and "internalization", the other two key elements of D'Amour and colleagues' model (D'Amour, Ferrada-Videla, San Martin, & Beaulieu, 2005), the historical development appears to have negatively affected the interprofessional collaboration between obstetricians and midwives. The formalization of the collaboration predominantly entailed the introduction of regulations restricting midwifery practice to the physiological processes of pregnancy and delivery, without any usage of instruments or medication (Schoon, 1995). Consequently, the obstetricians acquired a dominating position over the midwives, which led to numerous discussions about the position and authority of the midwife in maternity care (Klomp, 1996; Kroes-Suverein, 1998).

Although the historical development of interprofessional collaboration in Dutch maternity care has been especially difficult for the midwives, nowadays the nature of the

CONTACT Dr. Nadine van der Lee, MD nadinevanderlee@gmail.com OLVG Location West, Department of Medical Education, Jan Tooropstraat 164, Amsterdam 1061 AE, The Netherlands.

collaboration has changed and the position of midwives in Dutch maternity care has improved considerably. In today's maternity care practice, the midwives run an autonomous practice in the community, they hold a gatekeeper function for the care of the obstetrician in the hospital, and care responsibilities appear to be clearly divided between the professions. In a way, the midwives appear to have freed themselves from historical domination by the obstetricians.

Yet, although this might imply that obstetricians and midwives have overcome their historical problems in collaboration, the outcome of their combined effort in maternity care remains weak. A recent study by the Dutch Steering group on pregnancy and birth found a relatively high perinatal morbidity rate in the Netherlands compared to other European countries (Europeristat project, 2008). The causes for these findings are sought in the organization and coordination of Dutch obstetrical care as well as in a suboptimal collaboration between obstetricians and midwives (Adviesgroep Zwangerschap en geboorte, 2009). However, it remains unclear what exactly causes the collaboration to be suboptimal and whether the historical development has any influence in this matter.

An exploration of the collaboration as experienced by those involved could provide a better understanding of the different aspects of the collaboration, which in turn would help the different stakeholders identify interprofessional threats and opportunities. Subsequently, it allows us to more specifically and efficiently implement interventions aimed at improving the interprofessional collaboration and the corresponding provision of healthcare.

In this study, we aimed to gain a better understanding of the collaboration problems to improve the quality of Dutch maternity care from the perspectives of the professionals involved. As a first step, we explored the perceptions of midwives on their contemporary collaboration with obstetricians, by performing a focused secondary analysis of questionnaire data on the performance of Dutch obstetricians. For the analysis of the data, we used the interprofessional collaboration model of D'Amour (D'Amour et al., 2005). Our research question was: How do midwives perceive their collaboration with obstetricians now that their formal position has substantially improved?

Methods

Setting

In the Netherlands, maternity care is mainly provided by two professions, the midwives and the obstetricians. Community midwives provide prenatal and maternity care in the community. They are concerned with the physiology of pregnancy and the care surrounding physiological labour. Also, community midwives are authorized to guide home births. In acute maternity situations or if pathology during pregnancy is suspected, they refer patients to the obstetrician in the hospital. Almost all obstetricians work in a hospital and are concerned with the pathology of obstetrics. Most of them are also concerned with gynaecological care. Therefore in this article, an obstetrician is a professional in gynaecology as well as in obstetrics.

Data collection

To gain insight into the perspectives of the midwives on their collaboration with obstetricians, we undertook a focused secondary analysis of the questionnaire data of 57 midwives who had been included in a previous study. These data originated from a study performed between November 2009 and February 2010 and explored the perspectives of societal stakeholders on the performance of Dutch obstetricians using a questionnaire (van der Lee et al., 2013). In this previous study, a questionnaire was sent to patients, community midwives, general practitioners (GPs), specialized obstetrics nurses, and board members of Dutch hospitals. In the questionnaire, the stakeholders were asked to provide feedback on the performance of obstetricians by answering the following two open-ended questions:

- Describe three aspects of the performance of obstetricians that you consider to be positive (*strengths*).
- Describe three aspects of the performance of obstetricians that you consider to require improvement (*weaknesses*).

The purpose of the original study was to gather information on the performance of obstetricians in order to inform the redesign of the current Dutch postgraduate training programme for the specialty Obstetrics and Gynaecology. At the time of the original study, the Dutch local ethical review board of the Sint Lucas Andreas hospital ruled that this type of research was exempt from ethical approval. Therefore the informing of participants and the storing and analysis of the data were carefully completed in compliance with the Helsinki declaration. In an open coding analysis of the original qualitative data, the strengths and weaknesses were categorized in themes. Each theme reflected a competency in the performance of obstetricians that was highly appreciated by the stakeholders.

The open coding analysis of the data provided by the midwives in particular revealed that the majority of the midwives' feedback reflected on the collaborative performance of the obstetricians. Therefore, the present study provides a focused analysis of the midwives' data collected in the previous study. In line with the original study, the storage, handling, and secondary analysis of the data were completed in compliance with the Helsinki declaration. The original data were stored on a separate location on a computer, which was only accessible by the principal researcher. Before the analysis, the data were imported into another database on the principal researcher's computer and anonymized by deleting all parts of the text that might be traced back to a specific participant.

We looked for information on the collaborative performance of obstetricians, defining collaborative performance simply and broadly as any interaction between obstetricians and midwives. The purpose of this focused analysis was to consider whether existing theoretical frameworks on interprofessional collaboration would help complement or extend our current interpretation of the data and might thus lead to a better understanding of the aspects of the collaboration that cause difficulties for the midwives.

Analysis

We used template analysis to analyse the data (Cassell, 2004). This systematic form of thematic analysis allows themes to emerge in a hierarchically structured way from the data as well as from a theoretical framework. The first step in template analysis involves establishing a theoretical coding template by defining *a priori* themes that are expected to emerge during data analysis. For the theoretical coding template of the present study, we defined four overarching *a priori* themes and 10 *a priori* sub-themes based on the four elements and the 10 features of D'Amour's model on interprofessional collaboration (D'Amour et al., 2008). In her model, D'Amour distinguishes two domains of collaboration, the relational domain and the organizational domain. The relational domain includes the elements *shared goals and vision* and *internalization*, and the features *goals, client-centred orientation versus other allegiances, mutual acquaintanceship*, and *trust*. The organizational domain of collaboration comprises the elements *governance* and *formalization*, and the features *centrality, leadership, support for innovation, connectivity, use of formalization tools*, and *structured information exchange*.

The second step in the analysis consisted of initial coding of a subsample of the interview transcripts based on the *a priori* themes and sub-themes, which was conducted by the first author. In the next step, the first and third authors discussed this initial coding. Their viewpoints generally coincided, and the discussions mainly focused on categorizing codes that seemed to fit multiple themes. After the two authors reached consensus on the initial coding, an initial coding template was developed in which five sub-themes of the theoretical coding template were preserved and applied as themes. The theoretical two domains and the other themes and sub-themes were discarded. Two themes were added to the template (see Table 1). After this, the initial coding template with seven themes was applied to the entire data set by the first author. The authors regularly met to discuss issues that arose during the coding, such as resolving overlaps between several themes and sub-themes and finding names and definitions for newly found (sub)themes. In this process, a final coding template was developed, which was iteratively applied to the entire data set.

The next step in the analysis consisted of interpreting the coding results of the data set. The interpretation focused on identifying and understanding the components and dynamics of collaborative performance according to the final coding template. At the same time, a search for disconfirming evidence was conducted. A final interpretation was carried out, which resulted in the findings that are discussed in the next section, supported by illustrative quotes from the respondents.

Owing to the self-selecting nature of the recruitment of respondents and the pursuit of data saturation in the original study, a response rate could not be calculated in the current study. However, the analysis of the present study also showed data saturation, which means that the inclusion of further data would probably not have resulted in the identification of new themes.

Table 1. The theoretical coding template and the themes of the final coding template.

Theoretical coding template	Themes of the final coding template
Relational domain	Willingness to collaborate
Theme Shared goals and vision	Power imbalance
Goals	Trust
Client-centred orientation versus other allegiances	Mutual acquaintanceship
Theme Internalization	Structured information exchange
Mutual acquaintanceship	Use of formalization tools
Trust	Connectivity
Inter-organizational domain	
Theme Governance	
Centrality	
Leadership	
Support for innovation	
Connectivity	
Theme Formalization	
Use of formalization tools	
Structured information exchange	

Results

Our analysis revealed several influencing aspects at the relational level and at the organizational level of the midwives' collaboration with obstetricians.

Relational aspects of the collaboration

At the relational level of the collaboration, we found four themes to influence the midwives' collaboration with obstetricians.

Willingness to collaborate

First of all, according to the midwives, obstetricians tend to express a willingness to collaborate with the midwives. Midwives noticed being taken more seriously when consulting and communicating with obstetricians. Moreover, they reported a tendency among obstetricians to be more open to the midwife's opinion when care decisions were to be made by the obstetricians.

Power imbalance

Despite this willingness to collaborate, the midwives experienced a power imbalance in which the obstetricians rank themselves above the midwives. Midwives reported that they often did not feel acknowledged by obstetricians as being well-trained professionals and that they did not feel being taken seriously in the care they provide. In the collaborative performance of obstetricians, this power imbalance was expressed by treating midwives as inferior partners, taking a somewhat condescending and haughty attitude and frequently questioning the midwife's action, as indicated by this response:

> "In my surroundings, I sometimes notice that obstetricians consider themselves 'above' me. That is a matter of discussion, I did not attend a medical education, but a higher vocational education. However, we do have to work together." (participant 41)

Trust

Besides the perceived power imbalance, the midwives also reported a lack of trust in the midwife's practice and actions, which was demonstrated most clearly when a patient was

transferred to the hospital. The midwives experienced that the obstetricians, instead of trusting the midwife's insights and actions, tended to evaluate the patient all over again and to repeat the actions already taken by the midwife at the patient's home. According to the midwives, this led to unnecessary delay in patient care:

> "They often do not understand the reason why a patient was referred or they do not suppose that immediate action is required if they are called. They do not readily assume that we have already tried everything in the preliminary stages." (participant 14)

Fortunately, however, the midwives reported that a time-consuming repetition of preliminary activities usually did not occur in case of consultations or transfers involving life-threatening situations.

Mutual acquaintanceship

Moreover, according to the midwives, obstetricians have a lack of knowledge regarding the activities and responsibilities of a midwife and regarding the limited range of care offered by a community midwifery practice. This lack of knowledge was reported to lead to a lack of understanding and sometimes even to disrespect and to a condescending attitude towards the midwife's decisions, actions, and provision of care.

The midwives also reported that obstetricians lacked knowledge about the physiology of pregnancy and labour, which sometimes resulted in unnecessary and premature medical interventions.

"In my opinion, an obstetrician should have more regard for the physiology during parturition, which could limit unnecessary interventions (e.g. vacuum extraction)." (participant 40)

Organizational aspects of the collaboration

At an organizational level, we found three themes that influence the midwives' collaboration with obstetricians.

Structured information exchange

The midwives reported that the structure of information exchange from midwives to obstetricians was functioning properly. Moreover, when needed, obstetricians were easily approachable to discuss a patient with the midwife if she suspected a problem.

> "When we ask an obstetrician for advice or support (a consultation), we (and the pregnant woman we transfer) are often helped well. The request is taken seriously and dealt with appropriately."(participant 54)

The information exchange from obstetricians to midwives, however, was reported to require perfection. After a consultation or delivery of patients whose care had been transferred from the midwife to the obstetrician, obstetricians communicate relevant information much too late with the referring midwife or not at all. Lacking this information about the delivery and possible complications was perceived as inconvenient and potentially harmful, as the midwife is responsible for the follow-up of the patient's post-partum care at home.

Use of formalization tools

Moreover, midwives expressed a need for more interprofessional guidelines and protocols on the formalization of the collaboration and maternity care policy. Such formalization was thought to help clarify professional boundaries between both professions and to standardize provided care. However, they actually expressed a need for an attitudinal change on the part of the obstetricians, as the midwives reported that obstetricians tended to neglect or ignore the interprofessional guidelines and protocols that already exist.

> "Obstetricians tend to adhere very strictly to protocols and guidelines of their own society (the NVOG), but they are not open to other insights or points of discussion. 'There is no NVOG protocol for that yet', in such situations it is difficult to reach collaborative agreements." (participant 24)

In addition, the midwives reported that within the group of obstetricians, individual obstetricians tended to follow the treatment options they personally related to most. As a result, the treatment policy often changed during the day or night when the responsible obstetrician's shift was taken over by a colleague. This attitude was perceived to have a negative influence on the collaboration with midwives and sometimes even on patient care.

Connectivity

Finally, the midwives reported a need for connecting and discussing with the obstetricians. In interprofessional meetings, the midwives reported to want to discuss the provided care following a particular consultation, delivery, or incident with all parties involved.

> "Discussion or evaluation of parturition takes place in the hospital, in secondary care, but to improve communication, the primary care midwife should also be included in case of parturitions involving a transfer between primary and secondary care." (participant 19)

The midwives also expressed a need for opportunities for reciprocal sharing of possible changes and difficulties in practice, to develop consensual guidelines, and to improve the collaboration and quality of care.

> "Regular meetings of obstetricians and primary care, in order to clearly inform primary care about a hospital's new policy on induction, counselling in case of breech position or post-term pregnancy." (participant 17)

For some of the midwives, this need for connectivity was already fulfilled. They reported a well-functioning system of sharing experiences, meetings, and discussions on provided care, quality of care, and guideline development, in which there was an open atmosphere of communication and exchange of feedback. Due to the meetings and the open atmosphere, the midwives experienced a swift resolution of miscommunication and conflicts. Consequently, the meetings actually helped improve the collaboration and care provided, since discussions on provided care resulted in the evaluation, reconsideration, and revision of guidelines or practices.

> "Our multi-disciplinary meetings are almost always attended by several obstetricians. They feel very involved with our work and appreciate hearing our opinions on certain matters (and we appreciate their opinions, of course)." (participant 43)

"Irritations and miscommunications are quickly resolved thanks to consultation and direct interaction." (participant 22)

Discussion

In this secondary analysis study, we analysed the midwives' perspectives on their collaboration with obstetricians, using a model for interprofessional collaboration. Our results show interprofessional difficulties on both the relational and organizational levels of collaboration, which to some extent can be explained by the historical development of the collaboration.

On the relational level of interprofessional collaboration, our results show that contemporary practice is still influenced by the historical development of the relationship. Midwives report a power imbalance in which they are inferior to the obstetricians. This perception is probably caused by a history of belittling regulations and adjusting professional boundaries on the part of doctors (Klomp, 1996). And the perception seems to continue because of these historic roots, despite the midwives' well-defined and crucial role in Dutch obstetrics and despite the fact that midwives experience that obstetricians are willing to cooperate.

The perceived power imbalance could harm interprofessional collaboration and may be related to the experienced lack of trust and mutual acquaintanceship. Power inequalities are known to influence the entire process of interprofessional collaboration and can even set up a barrier for the effective collaboration in teams (D'Amour et al., 2005; King et al., 2008). The negative effect of the perceived power imbalance could be amplified by the obstetricians' reported lack of knowledge about the midwives' responsibilities and activities. A study within the practices of GPs showed that the extent of GPs' collaboration with and patient referral to allied health professionals was negatively influenced by the GPs' limited understanding of the roles and capabilities of those allied professionals (Chan et al., 2010). Furthermore, an unclear or incomplete understanding of one's own role and other professionals' roles in the collaboration is known to have a negative effect on a person's attitude towards collaboration and to inhibit collaboration skills (Fewster-Thuente & Velsor-Friedrich, 2008; Parsell & Bligh, 1999). Instead, mutual recognition of each profession's strengths and weaknesses leads to a greater willingness to interact (Carpenter, 2013) and thereby positively influences the effectiveness of the collaboration (King et al., 2008). Moreover, within the organizational level of the Dutch maternity care collaboration, historical developments might underlie contemporary difficulties. The midwife perspectives show a partially unmet need for connecting with one another, consensual guideline development, and improvement of collaboration and quality of care. The fact that obstetricians and midwives are historically organized in two different professional societies with their own visions, protocols, and political lobbies is easily understood from a historical perspective, but it is also potentially detrimental for optimal interprofessional governance. It might seem obvious for both professions that they might best serve the patient by sharing goals and visions, sharing patient forms, and sharing the same professional community.

Yet, the historical development of the collaboration might not be the only explanation for the problems in current Dutch maternity care. In the literature, some of our results, i.e. lack of an understanding of the roles and responsibilities, seeing one's own profession better than others, and the reported power imbalance could also be explained by the unidisciplinary way professionals have been socialized in schools and agencies. Throughout their education, professionals are trained in the spirit of a profession's standards, values, and practice. Implicitly, this training protects the continued existence of the profession and with that the preservation of professional boundaries as well as traditional power imbalances (Bourgeault & Grignon, 2013; Khalili et al., 2014; Reeves et al., 2010).

Owing to the deeply rooted shortcomings in both organizational and relational aspects of the collaboration, the contemporary collaborative problems are probably impervious to minor interventions and require disruptive changes (Christensen et al., 2000; Schuitmaker, 2012). Examples of such disruptive changes are a government-driven fusion of the professional societies, an insurance-driven financial structure demanding obstetricians and midwives to collaborate in a professional as well as a financial partnership, and a patient-driven demand for common protocols and procedures for midwives and obstetricians, sustaining their function as a team. This requires the midwives and obstetricians to leave their autonomous positions and to continue working as a true team. Yet, giving up one's autonomy might be perceived as a loss of status and for doctors this loss of status is known to inhibit their participation in a collaboration (Whitehead, 2007). And therefore also on the level of professional socialization and education, disruptive changes are appropriate.

This study has important limitations. Foremost, the data were collected with a view to informing the competency-based training of Dutch ObGyn residents. The original questionnaire was not developed with the explicit goal of evaluating the midwives' collaboration with obstetricians, but rather to evaluate the overall performance of obstetricians. The aspects of the performance concerning collaboration or interacting with other professions were selected from the original data. As the goal of the original questionnaire differs from the aim of the current study, important issues in the collaboration between midwives and obstetricians might have remained unmentioned. However, the data of 57 midwives evaluating the performance of obstetricians were dominated by remarks about the collaborative performance of obstetricians. As this indicates an urgent need for change of practice, we think that the most critical issues in the collaboration did feature in the present evaluation.

We chose to explore only the midwives' perspectives on the interprofessional collaboration in Dutch maternity care, because from a historical point of view this is the profession that has been the repressed party in the collaboration. To find clues for improving the interprofessional collaboration, the perspective of obstetricians on contemporary practice is indispensable. Therefore, an obvious next step would be to also explore the obstetricians' perspectives on the collaboration, followed by a discussion aimed at finding solutions for each of the problems that emerged.

The used model on interprofessional collaboration by D'Amour (D'Amour et al., 2008) is not the only model in the literature on factors influencing interprofessional teamwork. A model by Reeves et al. describes four domains in interprofessional teamwork that influence the process and outcomes of the teamwork: the relational, organizational, processual, and contextual domains (Reeves, Lewin, Espin, & Zwarenstein, 2010). Although the naming of the relational and organizational domains is similar to that of the model of D'Amour, the factors within the domains differ significantly. For example, Reeves' relational domain also includes factors like professional power, hierarchy, team roles, and team composition, whereas the model of D'Amour does not include these factors in the relational domain, nor in any other domain. In this light, the used model of D'Amour could be interpreted as incomplete and limited. Yet, despite its limited nature, the practical and recognizable naming and content of the factors very helpfully guided us in our exploration of the collaborative problems in Dutch maternity care.

In conclusion, this study shows it is important to explore how contemporary interprofessional practice is perceived by those involved and how the experienced collaborative difficulties are historically rooted. It provides a better understanding of the content, impact, and origin of the collaborative difficulties. Moreover, it helps us identify interventions that actually have the potential to solve interprofessional problems.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

References

Adviesgroep Zwangerschap en geboorte. (2009). *Een goed begin: Veilige zorg rondom zwangerschap en geboorte* (A good start: Safe care surrounding pregnancy and birth). Retrieved from http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2009/12/30/een-goed-begin-veilige-zorg-rond-zwangerschap-en-geboorte.html

Bourgeault, I. L., & Grignon, M. (2013). A comparison of the regulation of health professional boundaries across OECD countries. *The European Journal of Comparative Economics*, *10*, 199–223.

Carpenter, J. (2013). Doctors and nurses: Stereotypes and stereotype change in interprofessional education. *Journal of Interprofessional Care*, *9*, 151–161.

Cassell, C. (2004). *Essential guide to qualitative methods in organizational research*. London, UK: SAGE Publications.

Chan, B. C., Perkins, D., Wan, Q., Zwar, N., Daniel, C., Crookes, P., et al. (2010). Finding common ground? Evaluating an intervention to improve teamwork among primary health-care professionals. *International Journal for Quality in Health Care*, *22*, 519–524.

Christensen, C. M., Bohmer, R., & Kenagy, J. (2000). Will disruptive innovations cure health care? *Harvard Business Review*, *78*, 102–112.

D'Amour, D., Ferrada-Videla, M., San Martin, R. L., & Beaulieu, M. D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, *19*(Suppl. 1), 116–131.

D'Amour, D., Goulet, L., Labadie, J. F., Martin-Rodriguez, L. S., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Services Research*, *8*, 188.

De Vries, R. G. (2004). *A pleasing birth: Midwives and maternity care in the Netherlands*. Philadelphia, PA: Temple University Press.

Europeristat project. (2008). *European perinatal health report*. Retrieved from http://www.europeristat.com/images/doc/EPHR/european-perinatal-health-report.pdf

Fewster-Thuente, L., & Velsor-Friedrich, B. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly*, *32*, 40–48.

Houtzager, H. L. (1993). *Wat er in de kraam te pas komt: opstellen over de geschiedenis van de verloskunde in Nederland* (Papers on the history of obstetrical care in the Netherlands). Rotterdam, the Netherlands: Erasmus Publishing.

Janssens, J. (1997). Verloskunde en gynaecologie in de laatste 40 jaar (Obstetrics and Gynaecology over the last 40 years). *Nederlands Tijdschrift voor Geneeskunde*, *141*, 26–32.

Khalili, H., Hall, J., & Deluca, S. (2014). Historical analysis of professionalism in western societies: Implications for interprofessional education and collaborative practice. *Journal of Interprofessional Care*, *28*, 92–97.

King, H. B., Battles, J., Baker, D. P., Alonso, A., Salas, E., Webster, J., et al. (2008). TeamSTEPPS: Team strategies and tools to enhance performance and patient safety. In K. Henriksen, J. B. Battles, M. A. Keyes, & M. L. Grady (Eds.), *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 3: Performance and Tools)* (pp. 5–20). Rockville, MD: Agency for Healthcare Research and Quality.

Klomp, J. (1996). *Wat wilden ze, wat mochten ze en… wat mochten ze niet: de ontwikkeling van de bevoegdheid van vroedvrouwen onder de Wet regelende de uitoefening van de geneeskunst 1865–1993* (What they wanted and their authorizations: The development of the authorization of midwives under the law of medical practice). [S.l.]: Catharina Schrader Stichting.

KNOV. (2009). *History of the royal dutch organization of midwives*. Retrieved 24 June, 2013, from http://www.knov.nl/knov/historie

Kroes-Suverein, S. de. K. (1998). *De vroedvrouw … toen en nu: bevoegd en bekwaam* (The midwife.then and now: authorized and qualified). Bilthoven, the Netherlands: Catharina Schrader Stichting.

Macmillan, K. & Reeves, S. (2014). Interprofessional education and collaboration: The need for a socio-historical framing. *Journal of Interprofessional Care*, *28*, 89–91.

NVOG. (2013). *History of the dutch society of obstetrics and gynaecology*. Retrieved from http://www.nvog.nl/overNvog/Geschiedenis+NVOG/default.aspx

Parsell, G., & Bligh, J. (1999). The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS). *Medical Education*, *33*, 95–100.

Price, S., Doucet, S., & Hall, L. M. (2014). The historical social positioning of nursing and medicine: Implications for career choice, early socialization and interprofessional collaboration. *Journal of Interprofessional Care*, *28*, 103–109.

Reeves, S., Lewin, S., Espin, S., & Zwarenstein, M. (2010). *Interprofessional teamwork for health and social care*. Oxford, UK: Wiley-Blackwell.

Reeves, S., Macmillan, K., & van, S. M. (2010). Leadership of interprofessional health and social care teams: A socio-historical analysis. *Journal of nursing management*, *18*, 258–264.

Schoon, L. (1995). *De gynaecologie als belichaming van vrouwen: verloskunde en gynaecologie 1840–1920* (Gynaecologie as the embodiement of women: Obstetrics and Gynaecology from 1840 to 1920). Zutphen, the Netherlands: Walburg Pers.

Schuitmaker, T. J. (2012). Identifying and unravelling persistent problems. *Technological Forecasting and Social Change*, *79*, 1021–1031.

van der Lee, N., Driessen, E. W., Houwaart, E. S., Caccia, N. C., & Scheele, F. (2014). An examination of the historical context of interprofessional collaboration in Dutch obstetrical care. *Journal of Interprofessional Care*, *28*, 123–127.

van der Lee, N., Fokkema, J. P., Westerman, M., Driessen, E. W., van der Vleuten, C. P., Scherpbier, A. J. J. A., & Scheele, F. (2013). The CanMEDS framework: Relevant but not quite the whole story. *Medical Teacher*, *35*, 949–955.

Whitehead, C. (2007). The doctor dilemma in interprofessional education and care: How and why will physicians collaborate? *Medical Education*, *41*, 1010–1016.