'Naming and faming' maternity care providers: A mixed-methods study

Yvonne Kuipers [a,b,*], Vanessa De Bock [a], Natacha Van de Craen [a], Valerie Bosmans [a]

[a] Department of Health and Social Care, School of Midwifery, AP University of Applied Sciences, Noorderplaats 2, 2000 Antwerp, Belgium
[b] School of Health and Social Care, Edinburgh Napier University, Sighthill Campus, EH11 4BN Edinburgh, United Kingdom

ABSTRACT

Background: Positive benchmarking can serve as a catalyst for maternity care improvement.
Aim: To retrospectively benchmark Flemish maternity care providers' qualities, based on women's positive care experiences, and to explore which attributes of the different care providers contribute to these experiences.
Methods: A sequential, two-phased mixed-methods study benchmarking the qualities of the community midwife, the hospital midwife, and the obstetrician. An online questionnaire was used to collect the data among pregnant and postpartum women, who rated their care experiences with the various care providers using the Net Promoter Score. Non-parametric and post hoc tests established the differences between types of clinicians and between antenatal, intrapartum, and postpartum Net Promoter Score mean scores. Content analysis was used to construct a final pool of keywords representing attributes of care professionals, accumulated from the promoters' free text responses. Ranks were assigned to each keyword based on its frequency.
Findings: A total of 2385 Net Promoter Scale scores and 1856 free-text responses of 1587 responders were included. The community midwife received the overall highest NPS scores ($p < .001$). The promoters ($n = 1015$) assigned community midwives the highest NPS scores (9.67), followed by obstetricians (9.57) and hospital-based midwives (9.51). The distinct benchmarking attributes of community midwives were availability ($p < .001$), supportiveness ($p = .04$) and personalised care ($p < .001$). Being honest ($p < .001$), empathic ($p < .001$) and inexhaustible ($p = .04$) benchmarked hospital midwives. Calmness ($p < .001$), a no-nonsense approach ($p < .001$), being humane ($p = .01$) and comforting ($p = .02$) benchmarked obstetricians.
Discussion/Conclusion: The findings indicate that all care providers are highly valued, but community midwives are ranked the highest. The distinct differences between the care professionals can serve as exemplary performance for professional development and shape the profiles of maternity care professionals.

Introduction

Maternity care services in Flanders, the northern and Dutch-speaking part of Belgium, are structured hierarchically and are mainly overseen by obstetricians within a medical model of care. Obstetricians direct antenatal and intrapartum care in Flanders, with nearly all births (99.2 %) taking place in hospital (Christiaens et al., 2013; DeVlieger et al., 2021; Goemaes et al., 2020). Most childbearing women (99.5 %) opt for an obstetrician as their primary care provider during antenatal and intrapartum care. A hospital midwife and an obstetrician typically attend the birth in a hospital setting. The hospital midwife is usually unknown to the woman. After the birth, women remain in the hospital for approximately two days and receive care from hospital midwives. Once discharged, the community midwife provides further postpartum care (Helsloot and Walraevens, 2015). There has been an increase in

independent primary care midwives providing autonomous community care (Helsloot and Walraevens, 2015). Currently, 53 % of Flemish women receive care from community midwives at some point during the perinatal period, which can include antenatal, intrapartum, and/or postpartum care, although not all Flemish hospitals allow community midwives to autonomously provide intrapartum care to women in their caseload (Helsloot and Walraevens, 2015). The community midwife can be consulted until one year postpartum (Helsloot and Walraevens, 2015). Maternity care in Flanders is covered by the national health insurance.

Maternity care quality is increasingly being evaluated based on women's experiences and satisfaction, displaying a surge in interest in this area (Cellissen et al., 2022; Krol et al., 2015; Robert and Cornwell, 2013; Willmington et al., 2022). Traditionally, the focus of performance measurement has been on technical interventions and adverse events

rather than on women's satisfaction and experiences (Baxter et al., 2016; Escuriet et al., 2015). To address this gap, the International Consortium for Health Outcomes Measurement (IHCOM) developed patient-reported experience measures in addition to clinical indicators. However, the standardised closed questions used to report patient experiences are inadequate in capturing the (subjective) nuances of patient-care provider interaction associated with patient satisfaction (De Rosis et al., 2020)—whereas personal strengths and qualities of healthcare professionals are instrumental in shaping the maternity care (lived) experience (Kuipers et al., 2021; Mannava et al., 2015).

The experiences at the interpersonal care provider-service user level, is addressed by healthcare benchmarking through measuring and analysing personal strengths and qualities of care professionals and identifying positive care behaviour (Ettorchi-Tardy et al., 2012). Identifying professionals' positive care behaviour is best established by service users from which quality indicators can be derived (Baxter et al., 2016). Maternity care promoters, recognised as loyal, satisfied, and enthusiastic service users (Torres et al., 2009) are by far the best individuals to benchmark the positive personal assets of maternity care professionals and to provide valuable feedback, providing care professionals with insights in learning from the excellence of themselves and/or others (Kelly et al., 2016; Torres et al., 2009). The use of women's reporting to appraise the performance of maternity healthcare professionals can serve as a catalyst for enhancing the quality of care provided, and as a facilitator of a positive culture in maternity services. Positive benchmarking by highlighting high standards, so called "*naming and faming*"— of that which is desired or something to be proud of—can help to enhance the reputation of maternity care professionals (Adams et al., 2022; Bevan et al., 2019; Collins-Fulea et al., 2005; Harrison et al., 2015). Positive benchmarking has the potential to attract and retain high-quality professionals in the field and to enhance motivation and resilience (Kelly et al., 2016). Identifying the attributes of clinicians associated with good or excellent experiences of service users has a positive reinforcing effect on healthcare professionals and their professional development (Baxter et al., 2016; Borghini et al., 2021; Ettorchi-Tardy et al., 2012). That is, only when emphasis is placed on the exemplary performance of the care professionals (Baxter et al., 2016). To integrate women's voices in evaluating quality-of-care professionals, it has been recommended to do this using a survey supplemented with a qualitative approach (Cellissen et al., 2022).

The aims of this study were to (1) positively benchmark the Flemish maternity care providers based on the highest levels of patient/woman experiences (promoters) with antenatal, intrapartum, and/or postpartum care, either provided by the community midwife, the hospital midwife, and/or the obstetrician; and (2) explore which excellent attributes contribute to women's positive experiences with the different care providers. Positive benchmarking in this study involves several steps, including data analysis and qualitative investigation of factors that support the observed performance (Ettorchi-Tardy et al., 2012; Willmington et al., 2022).

Methods

Design

This study is a mixed-methods QUAN-qual sequential study (Schoonenboom and Johnson, 2017) carried out among pregnant and postpartum women in Flanders (Belgium), with the performance-level benchmarking across various maternity care providers, based on women's reported experiences as main measure.

Sample

Participants were eligible if they were receiving antenatal care or had received intrapartum and/or postpartum care from a community midwife, hospital midwife, and/or obstetrician in Flanders. Two cohorts were formed for the study: (1) the pregnancy and (2) childbirth cohort. Pregnant women were included during any trimester of pregnancy. Postpartum women were included when they had given birth one year prior to participation. Women giving birth before 32 weeks of pregnancy were excluded, as were those who had given birth <6 weeks to reduce the impact of the birth on recall (Schulz and Wirtz, 2020; Waldenström, 2004).

Sampling

We utilised various non-probability recruitment strategies such as convenience sampling, voluntary response sampling, and snowballing. We contacted 90 community midwifery practices in Flanders to distribute the study invitation among pregnant and postpartum women via flyers and posters. We approached five Flemish maternity units to display posters and circulate the flyers. This ratio reflects the distribution of community midwives and maternity hospitals in Flanders. Midwives and hospitals acted as "gatekeepers" to contact potential participants. We additionally recruited participants via approximately 100 open social media platforms that specifically target pregnant women and young mothers in Flanders. A Uniform Resource Locater (URL)-link or Quick Response (QR)-code that was included in the posters, flyers, and social media posts anonymously directed participants to the questionnaire.

Data collection

Data were collected between February 28 and July 22, 2022, using online questionnaires. Cohort 1 participants were asked to reflect on their current pregnancy, and cohort 2 participants were asked to reflect on their last labour and birth and/or postpartum period. Participants were asked to report their satisfaction with the community midwife, hospital midwife, and/or obstetrician. Participants could select more than one maternity care professional.

Measures

The outcome of interest was women's self-reported experiences with one or more maternity care professionals during care encounters in pregnancy, birth, and postpartum. Per care provider, responders were asked to rate their experiences on a scale of 1 (not satisfied) to 10 (very satisfied), phrased as: "how would you rate your experience?" The rating was followed by an open-ended free-text item for participants to freely and unstructured elaborate on their score. Information about sociodemographic and personal details was collected. The questionnaire was available in the Dutch, French, and English languages.

Ethical statement

The Ethics Committee Social and Human Sciences Antwerp University (SHW_22_04, 16 February 2022) approved the study after review of the research proposal, the information letter for participants, the informed consent form, and the questionnaire. Before initiating the survey, all respondents signed an electronic informed consent form, which was built into the online questionnaire.

Analysis

Statistical analysis

The analyses were performed using the Statistical Package for the Social Sciences© (SPSS) version 28. We calculated descriptive statistics for the participants' sociodemographic and personal details. For analysis and interpretation of the ratings, we applied the criteria of the Net Promoter Score (NPS), a measure used within (non)profit organisations and in health care (Bevan et al., 2019; Krol et al., 2015). Respondents scoring 9–10 were categorised as promoters (satisfied loyal enthusiasts), 7–8 as passives (satisfied but non-enthusiasts), and respondents scoring

≤6 were categorised as detractors (unhappy service users). The overall NPS was calculated as the % Promoters – % Detractors (Krol et al., 2015). The normality of NPS distribution was checked with the Shapiro–Wilk test. Kruskal–Wallis tests established the differences in mean NPS between types of clinicians and between antenatal, intrapartum, and postpartum NPS mean. Bonferroni post hoc tests examined further significance. When significance in differences was shown, a Welch ANOVA with *post hoc* Bonferroni test was performed. The *p*-value was set at <.05. An a priori sample size calculation showed that we needed a minimum of 382 participants for both pregnant and intrapartum/postpartum samples (*p* < .05, CI 95 %).

Content analysis

To identify the reasons behind the highest scores, a further analysis of the free text answers of the promoters (scores 9–10) was executed. At this point, the passives and detractors were excluded from the analysis. Per care provider, the free-text data was organised in Excel for content analysis (Bengtsson, 2016). Two researchers independently searched the free texts for meaning units and independently extracted codes (nouns, adjectives, and verbs). The codes were compared and categorised, and further compiled into keywords that represented the attributes. This process of decontextualization, recontextualization, categorization, and compilation of keywords was discussed among all researchers. The keywords were configured and compared so that all synonyms and derivatives could be merged into a final pool of terms (Bengtsson, 2016). All keywords were quantified, and a Chi-square test adjusted for the p-values with the Bonferroni method was used to show the significant differences and similarities between the care professionals. The keywords showing a statistically significant difference between the care

professionals (*p* < .05) were entered in the word analysis program Wordart©. Per care professional, the keywords were displayed in a word cloud. The weight of the number of times a word occurred influenced the size at which the keywords were displayed in the word cloud, visualising which attributes benchmarked each care professional. Examples and quotes from the open-text answers illustrate the attributes.

Results

A total of 2475 questionnaires were received, of which 323 were removed due to incomplete socio-demographic details and no consent given (13 % non-responders). Of the remaining 2152 (87 %) responders, 341 were removed based on inclusion- and exclusion criteria, and 224 questionnaires were removed due to missing NPS scores, leaving 1587 completers (64.1 % completion rate) (Fig. 1). The 1587 completers provided a total of 2385 NPS, and 1257 completers gave 1856 free-text answers. A total of 909 participants scored one maternity care professional, and 678 participants scored two or more maternity care professionals. On average, each participant completed 1.5 (±0.66, range 1–6) NPS. Cohort 1 (434 participants) completed 472 NPS (per participant on average 1.08 ± 0.28, range 1–3). Cohort 2 (1153 participants) completed a total of 1913 NPS; 1295 intrapartum NPS (per participant on average 1.3 ± 0.59, range 1–6) and 618 postpartum NPS (per participant on average 1.83 ± 0.64, range 1–6). Responders most often scored intrapartum care (54.3 %), followed by postpartum care (25.9. %) and antenatal care (19.8 %). Responders most often scored the community midwife (44.8 %), followed by the obstetrician (40 %) and the hospital midwife (15.2 %).
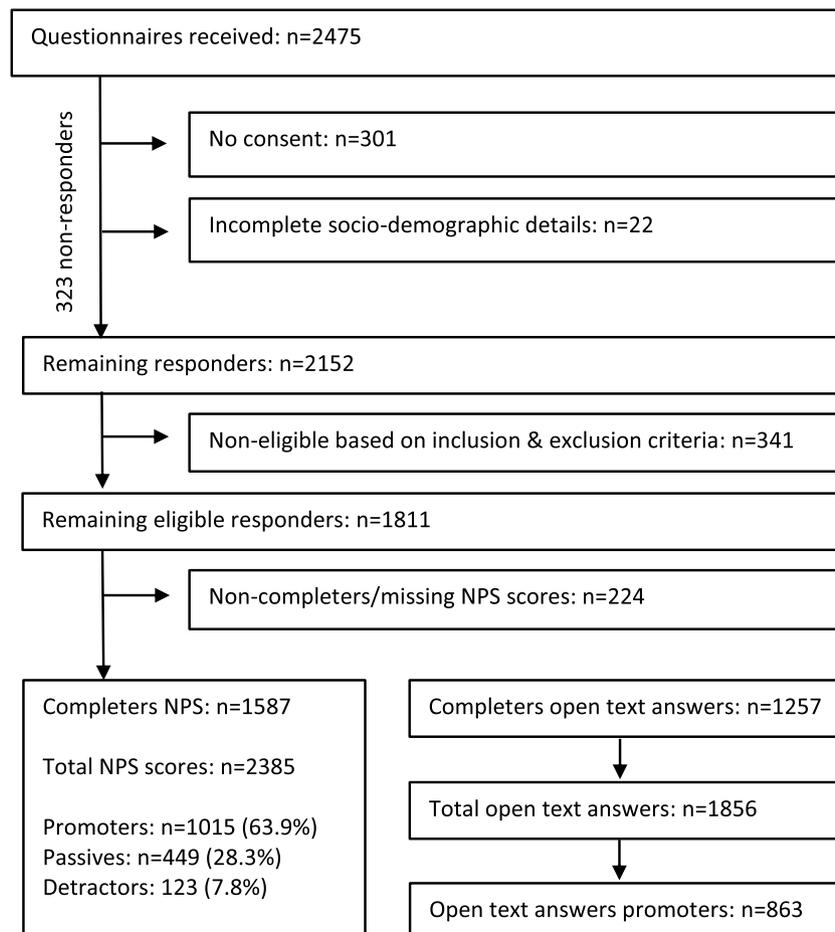

Fig. 1. Flowchart participants.

Participants

The participants were predominantly born in Belgium (92.8 %). Most of the participants had a relationship (96.7 %), a job (89.4 %), and reported high levels of education (62 %). The sample included nearly two-thirds of multiparous women (59.6 %) (Table 1). Cohort 1 included statistically significantly more multiparous women compared to cohort 2 (71.4 % % vs 55.2 %) (*p* < .001). Of the cohort 2 participants, 79.6 % had a spontaneous vaginal birth, and 7 % had an out-of-hospital birth.

Net Promoter Score (NPS)

The Shapiro–Wilk test showed a non-normal distribution for the NPS (*W* = 0.75, *p* < .001). The total NPS was +52.8, consisting of % promoters (62.9 %) – % detractors (10.1 %).

Differences between NPS categories

Kruskal–Wallis indicated statistically significant differences between the NPS categories (*p* < .001).

Detractors scored a NPS mean of 4 (±1.8, range 1–6), passives 7.7 (±0.5, range 7–8) and promoters scored a NPS mean of 9.6 (±0.5, range 9–10).

NPS differences between the various maternity care professionals

Kruskal–Wallis showed statistically significant differences between maternity care professionals. Overall, the responders assigned the community midwife the highest NPS mean (9.03, ±1.37, range 1–10), followed by the obstetrician (8.18, ±2.02, range 1–10) and the hospital midwife (7.96, ±2.33, range 1–10) (*p* < .001). The scores from the promoters showed the same significant differences. The promoters assigned the community midwife the highest NPS mean (9.67, ±0.47, range 9–10), followed by the obstetrician (9.57, ±0.50, range 9–10) and the hospital midwife (9.51, ±0.50, range 9–10) (*p* < 0.001).

NPS differences throughout the perinatal period

Kruskal–Wallis showed statistically significant NPS differences (*p* < .001) throughout the perinatal periods (pregnancy, birth, and postpartum). A post hoc (Welch) Bonferroni test indicated no statistically significant differences (*p* = .11) and further analysis was discontinued.

Table 1
Details participants.

	All participants (*n* = 1587) Mean (SD±) range
Age participants (in years)	30.3 (±4.2) 18–46
Number of pregnancies	2.0 (±1.2) 1–10
Length of gestation (in weeks)	25.1 (±9.3) 4–41
Gestational age at birth (in weeks)	39.1 (±1.6) 32–44
Postpartum period (in weeks)	24.4 (±14.2) 6–53
	N (%)
Nulli/primiparous women	641 (40.4)
Multiparous women	946 (59.6)
Born in Belgium	
Yes	1473 (92.8)
No	114 (7.2)
Relationship:	
In a relationship	1534 (96.7)
Single	53 (3.3)
Highest level of education:	
Primary education	42 (2.7)
Secondary education	549 (34.6)
Bachelor/ Master/ PhD	996 (62.7)
Work situation:	
Paid job	1384 (87.2)
Unpaid job	35 (2.2)
Student	25 (1.6)
Job seeking	43 (2.7)
Maternity/parental leave/benefits	100 (6.3)

Free text analysis

The sample consisted of 63.9 % (*n* = 1015) promoters who provided 863 free-text answers (Fig. 1). From the free-text answers, we extracted 1617 meaning units, from which we accumulated a total of 50 different keywords. Forty-eight keywords represented the attributes of community midwives, with most entries for availability (*n* = 173). Forty keywords represented obstetricians, with most entries for informative (*n* =

Table 2
Attributes of community-, hospital-based midwives and obstetricians.

Attributes	Community midwife	Hospital midwife	Obstetrician	Total	P-value
Availability	173	4	26	203	<.001*
Informative	98	23	73	194	<.001*
Supportive	95	25	30	150	.040*
Listening	72	12	56	140	<.001*
Takes time	69	13	31	113	.64
Personalised care	34	1	2	37	<.001*
Kindness	33	39	2	74	<.001*
Reassuring	30	9	31	70	<.001*
Attentive	23	2	6	31	.23
Problemsolving	19	1	4	24	.13
Involved	18	0	12	30	.026*
Understanding	18	8	18	44	.012*
Shared decision-making[a]	14	5	10	29	.35
Respectful	12	5	12	29	.07
Awareness	12	3	4	19	.88
Calmness	13	10	27	50	<.001*
Considerate	12	4	14	30	.017*
Compassionate	10	2	15	27	.001*
Informed choice	9	1	2	12	.58
Caring	10	6	4	20	.09
Physiological approach	11	1	0	12	.07
Approachable	9	0	2	11	.27
Empowering	8	0	0	8	.07
Trustworthy	12	2	10	24	.16
Empathy	7	15	1	23	<.001
Honest	6	25	1	32	<.001
Patience	6	3	2	11	.39
Consent	8	1	2	11	.71
Encouraging	6	7	4	17	.003*
Continuity of care	6	0	0	6	.14
Woman's advocate	6	1	0	7	.28
Calming	5	2	3	10	.31
Compliant	5	3	5	13	.24
Collaborative	5	1	4	10	.57
Motivating	6	2	3	11	.88
Referral	5	0	1	6	.46
Holistic	5	0	0	5	.19
One-to-one care	4	1	0	5	.41
No-nonsense	4	0	24	28	<.001*
Dedicated	4	2	2	8	.63
Humane	3	1	7	11	.01*
Balanced presence	2	3	0	5	.008*
Realistic	1	0	1	2	.68
Comforting	1	0	4	5	.02*
Evidence based	1	0	2	3	.25
Neutral	1	0	1	2	.68
Proactive	0	0	1	1	.23
Enthusiastic	1	0	0	1	.72
Culturally sensitive	1	0	0	1	.72
Inexhaustible	0	1	0	1	.04*
TOTAL	**907**	**462**	**248**	**1617**	

[a] All stages of shared decision-making mentioned according to Elwyn et al. (2012).

* P-value <.05: Attributes showing statistically significant differences between all maternity care providers.

73) and 36 keywords represented the attributes of hospital midwives, with most entries for kindness ($n = 39$) (Table 2). The attributes availability, informative, supportive, listening, personalised care, kindness, reassuring, being involved, understanding, calmness, considerate, compassionate, empathy, honesty, encouraging, no-nonsense, humane, balanced presence, comforting and being inexhaustible showed statistical differences between the maternity care professionals (Table 2).

The community midwife

The community midwife's unique benchmarking attributes are being available ($p < .001$), being supportive ($p = .04$) and providing personalised care ($p < .001$) (Table 2). Availability was described in terms of time, the availability of the community midwife as a resource of information and support, and the availability of a midwife within proximity. Promoters reported to be able to contact (phone, message, or visit) the community midwife for questions or concerns: *"I had the feeling I could always rely on her...She took time for me, she was there when I needed her... She was there (for me) as a helpline, a resource of helpful information...Easy to contact."* Supportive referred to the support of psychological and not only the physical aspects of pregnancy and birth, the midwife's support during the birth, the support of aiming for and achieving a physiological birth, supporting women's choices and decisions, and providing practical support (advice) during the antenatal and postpartum period: *"She never pushed me into making decisions, anything goes...She supported me when I was in doubt about what to do, when I was scared or worried...Her tips and tricks were really helpful and supportive...Her support helped me to achieve a natural birth...Her breastfeeding support was amazing."* Personalised care was described as a midwife with a personal and individualised approach, making an effort to build a relationship with the woman and being receptive to the needs and preferences of the individual woman: *"A midwife who knows me, who is interested in my needs, who makes the effort to get to know me, who meets my needs, who is interested in what I need, who sees me as an individual...A personal connection... All advice was tailored to me and my personal situation...Every time she considered "me": my wishes, my needs, my baby, my situation."* (Fig. 2).

The hospital midwife

The hospital midwife's unique benchmarking attributes are being honest ($p < .001$), empathic ($p < .001$) and inexhaustible ($p = .04$) (Table 2). Although being inexhaustible showed statistical significance; this key term occurred only once in the free-text data, mentioned by one participant. Being honest was described as a midwife who was open and honest in situations when things didn't go as planned or anticipated: *"She gave clear information when I had to go for an emergency section...She was very honest and transparent, so I knew what was happening...She did not stop me from raising my concerns and fully informed me and my partner, discussing everything we needed to know...She was open about the disadvantages."* Empathy referred to a midwife showing sympathy and

understanding for the labouring woman: *"She completely placed herself in my rhythm and my needs... She really understood me, showing sympathy for me and for my situation...We established a great rapport."* Being inexhaustible was described as *"limitless energy"* (Fig. 3).

Shared attributes between community and hospital midwives

Both the community and hospital midwives statistically significantly differed from the obstetrician by their kindness ($p < .001$), being encouraging ($p = .003$), and their balanced presence ($p = .008$) (Table 2). Words used to describe kindness were *"nice,"* *"kind,"* *"friendly,"* *"considerate,"* *"sweet,"* *"good,"* *"lovely,"* *"loving."* The community midwife's encouragement referred to stimulating the woman's self-management of the antenatal process and caring for the baby in the postpartum: *"She encouraged me to make my own decisions and to voice my wishes...She encouraged us to handle our baby in our own way".* The hospital midwife's encouragement applied to labour and birth and breastfeeding: *"She was very encouraging during my contractions; she encouraged me throughout the birth...She kept positively encouraging me to continue breastfeeding."* The balanced presence of both community- and hospital midwives referred to labour and birth, being present when needed and when suiting the woman and fitting the situation, and the art of 'doing nothing': *"The midwife was there, present when appropriate, doing the appropriate thing and saying the appropriate thing at the appropriate time, attuned, in the background...Not invading my bubble...She only stepped in, when necessary, needed, or when asked...Everything she did was tailored to the situation."*

The obstetrician

The obstetrician's unique benchmarking attributes are calmness ($p < .001$), no-nonsense approach ($p < .001$), being humane ($p = .01$) and comforting ($p = .02$) (Table 2). Calmness was described as how the obstetrician was able, through his or her presence and communication, to destress or de-escalate a situation: *"She made me not to worry too much...She created a very relaxed atmosphere...He calmed me down when I panicked."* No-nonsense referred to the obstetrician's approach while informing the woman during care. The words to describe the no-nonsense approach were *"to-the-point,"* *"straightforward,* *"say it as it is,* *"up front,"* *"straight to the point,"* *"no-nonsense,"* *"direct"*: *"He stated the facts whether they were good or bad...He did not beat around the bush and did not hide anything...He told it like it was."* Humane refers to the response of the obstetrician in a situation where foetal anomalies or foetal death occurred: *"He reacted so humanly when we found out about the baby having problems...Such a normal, humane response...There was a humane connection."* Comforting refers to feeling comfortable and secure: *"I felt at ease in the obstetrician's care...She made me feel at ease."* (Fig. 4).

Shared attributes between obstetricians and community midwives

Both the community midwife and obstetrician statistically significantly differed from the hospital midwife by listening ($p < .001$), being

The black coloured words are the characteristics/attributes unique for the community midwife, statistically different from the other two care professionals. The grey-coloured words are characteristics/attributes shared with the hospital-based midwife or obstetrician.

Fig. 2. Word cloud community midwife.

The black coloured words are the characteristics/attributes unique for the hospital midwife, statistically different from the other two care professionals. The grey-coloured words are characteristics/attributes shared with the community midwife.

Fig. 3. Word cloud hospital midwife.

The black coloured words are the characteristics/attributes unique for the obstetrician, statistically different from the other two care professionals. The grey-coloured words are characteristics/ attributes shared with the community midwife.
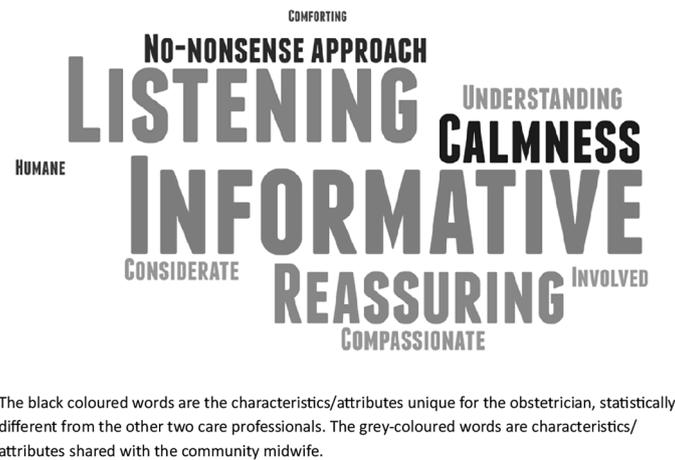
Fig. 4. Word cloud obstetrician.

informative ($p < .001$), reassuring ($p < .001$), involved ($p = .026$), understanding ($p = .012$), considerate ($p = .017$), and being compassionate ($p < .001$) (Table 2). Promoters reported that the community midwife listened to the woman's needs, questions, choices, opinion, problems, worries, concerns, personal story, wishes, experiences, emotions, and feelings. The obstetrician listened to the woman's opinion, needs, and wishes. The promoters reported that being informative related to the content of the information and to the way the information was given. The community midwife was informative about the birth process, place of birth, the birth plan, the care pathway, (vaginal) examinations, emotional wellbeing, breastfeeding, and practical tips & tricks during pregnancy, birth, and postpartum (recovery): *"Information about absolutely everything…She informed me about everything she was going to do."* The obstetrician was informative about interventions such as ultrasound and pain relief. Sufficient, necessary, detailed, correct, consistent, reliable, knowledgeable, exemplary, and explanatory information provided in a clear, understandable, professional, honest, and unbiased way applied to both care professionals. The presence, availability, information, and practical and emotional support of the midwife was reassuring, as was the fact that the midwife believed in the woman and her ability and strength to give birth: *"She made me believe in myself…I was not alone, the fact we could rely on her as a source of information and help was very reassuring… She made me feel so confident."* The expertise of the obstetrician and the fact that the obstetrician sought solutions for problems or symptoms, did extra tests, and provided information were reported as reassuring: *"Our first child had one kidney, every time I had an appointment, the obstetrician scanned the baby's kidneys to reassure me…When everything went wrong, first with the induction, then the epidural, he did a c-section, that was very reassuring otherwise I don't know what would have happened, he said it was better to be safe than to be sorry; all very reassuring."* Involvement of the community midwife related to being involved in the woman's and her family's life throughout the antenatal-intrapartum-postpartum continuum while the obstetrician was involved in the woman's care management and pathway. The obstetrician was perceived as gaining understanding by listening to the woman: *"He understood what I said,"* while the community midwife was described as: *"She heard me, and I felt understood."* Considerate referred to the thoughtfulness of both care professionals towards possibilities and towards the preferences and needs of women. In terms of compassion, both care professionals were perceived as sympathetic, showing sympathy in difficult situations, but the community- midwife was also described as: *"Caring deeply."*

No attributes shared between the obstetricians and hospital midwives showed a statistically significant difference compared to the community midwives (Table 2).

Discussion

In this study, we *named and famed* three Flemish maternity care providers who all play a profound role in maternity care services: the community midwife, the hospital midwife, and the obstetrician. To the best of our knowledge, this is the first study that benchmarks different maternity care providers from the positive perspective of women who are recognised as promoters of maternity services. This study shows that although the community midwife had the highest NPS mean, the other maternity care professionals are also highly valued. All key terms related to the interpersonal manner of the three professionals, lacking mention of technical competences or system issues (López et al., 2012). This study showed that the three maternity care professionals have their own unique interpersonal assets, but they also share certain strengths and qualities, albeit with content nuances. The community midwife was characterised with the highest number of keywords, reinforcing the competence of this midwife in the affective domain (Krausé et al., 2020).

Two-thirds of our sample was categorised as promoters, suggesting that many women are satisfied with their care professionals. The promoter scores represent high ratings which is not unusual for studies on maternity care experiences (Baas et al., 2017; Fontein-Kuipers et al., 2019). A ten-point grading scale is used in the grading percentage of Belgian higher education, with a minimum score of 5 or 50 % being the threshold for passing a test, although this score is considered a "detractor" in the NPS classification. A score of 8 or 80 % is considered a very good result in the Belgian context, but the NPS considers it "passive". This suggests that the promoters in our study are thus "real promoters" of Flemish maternity servicers (Krol et al., 2015). It is of interest to consider if the positive descriptions were based on women's norms, preferences, or expectations of the specific healthcare professional or on positive deviances. A positive deviance is when healthcare professionals show behaviour uncommon for or different from colleagues belonging to the same professional group—in our case, midwives, or obstetricians—but nevertheless show an asset for their professional group (Baxter et al., 2016). Regardless of whether the positive descriptions of the promoters derived from expectations or positive deviation, it does inform women whether a certain care professional suits their individual interpersonal interaction needs (Kuipers et al., 2021). Because indicators for positive deviants for care professional groups defined by service users are limited (Baxter et al., 2016), this study could be a first step in defining interpersonal assets of maternity care providers. Further exploration of the origin of the experiences—as in normative or positive deviances—would be of interest for their broader use and meaning. Most NPS relate to the intrapartum period, suggesting this period is important to women and worth reflecting on.

Maternity care services and their providers are currently criticised

and scrutinised (Ockenden, 2022) and therefore a prominent turn towards signalling positive experiences during pregnancy, labour, and postpartum from the voices of childbearing women seems crucial (Kwee et al., 2020). By no means do we have the intention to deny or trivialize negative experiences of women in maternity services (Kuipers et al., 2023). However, the findings of this study might benefit the entire maternity care services, including women—because care professionals are more likely to change their behaviour based on positive feedback on personal qualities and strengths (Baxter et al., 2016; Collins-Fulea., 2005; Kelly et al., 2016; Willmington et al., 2022). The utilisation of women's positive reporting, broadcasting the performance of maternity healthcare professionals, can serve as a catalyst for enhancing the quality-of-care and as a facilitator of a positive culture in maternity services, to attract and retain high-quality and motivated professionals in the field (Adams et al., 2022; Bevan et al., 2019; Collins-Fulea et al., 2005; Harrison et al., 2015). Additionally, identifying the personal attributes of healthcare professionals can influence regulatory bodies and education programs in shaping the profiles of maternity care professionals and can be used for reflective practice as part of professional development (Collins-Fulea et al., 2005).

Limitations

The generalisability of the findings may be impaired by our sample. The women in our sample predominantly had a Belgian background, high levels of education, more out-of-hospital births, and more spontaneous vaginal births compared with national data (DeVlieger et al., 2021; Goemaes et al., 2022; Statebel, 2022; Statistics Flanders, 2022). Moreover, because of the Belgian maternity culture (Christiaens et al., 2013; DeVlieger et al., 2021; Helsloot and Walraevens, 2015), our findings might be cultural appropriate and not transferable to differently organised maternity care settings.

The validity of our findings relies on the accuracy of women's recall of subjective interpersonal care experiences. The women in cohort 2 were asked to retrospectively report on their intrapartum and postpartum experiences. Although women typically recall their maternity care experiences with considerable accuracy even years later (Rijnders et al., 2008), we nonetheless recommend consideration of this when interpreting the findings (Schulz and Wirtz, 2020; Waldenström, 2004). It could very well be that the NPS represented the sum of interactions with a care professional (Harrison et al., 2015). We are unaware if women reflected on a single moment with a specific individual clinician or on the whole of their clinical encounters, reflecting on more than one individual care professional. However, more than half of the sample consisted of multiparous women, women with more than one perinatal experience, and often responders evaluated more than one healthcare professional, allowing them to compare the different clinicians and reducing bias. Additionally, we did not specifically ask participants to describe excellent attributes but instead asked them to elaborate on their experiences in their open-text answers, possibly contributing to an underreport of care professionals' strengths and qualities. It can be recommended to further explore additional factors affecting the positive care experiences of women in maternity care services. Finally, our scores ranged from 1 to 10, while the original NPS ranges from 0 to 10 (Krol et al., 2015). Because the total sample included a small percentage of detractors, the effect on the mean NPS score and the distribution of the scores can be waived.

Conclusion

The study provides valuable insights into the perceptions of Flemish pregnant and postpartum women regarding their interpersonal experiences with different maternity care providers. This study is the first to benchmark different maternity care providers based on the positive experiences of women. Although the community midwife had the highest NPS scores, the study highlights the unique and positive

attributes of all maternity care providers—information that can influence regulatory bodies and education programs in shaping the profiles of maternity care professionals. Although the study has limitations, it makes a significant contribution to benchmarking the personal qualities and strengths of maternity care professionals. The study emphasizes the importance of signalling positive perinatal experiences, especially in a field currently facing criticism and scrutiny. Understanding the distinct differences can help women in reflecting on their personal needs and which caregiver has the attributes that fit her needs. Understanding the distinct differences can facilitate a positive culture in maternity services, serve as exemplary performance for professional development, and shape the profiles of maternity care professionals. The results are relevant for maternity care providers, healthcare organisations, policymakers, education, and the wider public.

Statement of Significance

Problem or issue

Little is known about how maternity service users positively benchmark the interpersonal manner of maternity care providers.

What is already known

Benchmarking identifies the best performers in care services, their exemplary performance, contributing to proud professionals and a positive culture in healthcare services.

What this paper adds

Different maternity care professionals have their own unique assets; the mutual strengths and qualities vary in content.

CRediT authorship contribution statement

Yvonne Kuipers: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Supervision, Funding acquisition. **Vanessa De Bock:** Methodology, Formal analysis, Validation, Writing – review & editing. **Natacha Van de Craen:** Methodology, Formal analysis, Validation, Writing – review & editing. **Valerie Bosmans:** Investigation, Resources, Project administration, Writing – review & editing.

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.

Acknowledgements

References

Adams, C., Walpola, R., Schembri, A.M., Harrison, R., 2022. The ultimate question? Evaluating the use of Net Promoter Score in healthcare: a systematic review. Health Expect. 1–12. https://doi.org/10.1111/hex.13577.

Baas, C., Wiegers, T., de Cock, P., Erwich, J.J., Spelten, E.R., de Boer, M.R., Hutton, E.K., 2017. Client-related factors associated with a "less than good" experience of midwifery care during childbirth in the Netherlands. Birth 44 (1), 58–66. https://doi.org/10.1111/birt.12266.

Baxter, R., Taylor, N., Kellar, I., Lawton, R., 2016. What methods are used to apply positive deviance within healthcare organisations? A systematic review. BMJ Qual. Saf. 25 (3), 190–201.

Bengtsson, M., 2016. How to plan and perform a qualitative study using content analysis. NursingPlus Open 2, 8–14. https://doi.org/10.1016/j.npls.2016.01.001.

Bevan, G., Evans, A., Nuti, S., 2019. Reputations count: why benchmarking performance is improving health care across the world. Heal. Econ. Policy Law 14 (2), 141–161.

Borghini, A., Corazza, I., Nuti, S., 2021. Experience of the maternal and child care pathway. Int. J. Environ. Res. Public Health 18 (4), 1481. https://doi.org/10.3390/ijerph18041481.

Cellissen, E., Vogels-Broeke, M., Korstjens, I., Nieuwenhuijze, M., 2022. Integrating women's voices in quality improvement for maternity care: a qualitative study. Eur. J. Midwifery 6, 1–7. https://doi.org/10.18332/ejm/152253.

Christiaens, W., Nieuwenhuijze, M.J., de Vries, R., 2013. Trends in the medicalisation of childbirth in Flanders and the Netherlands. Midwifery 29 (1), e1–e8.

Collins-Fulea, C., Mohr, J.J., Tillett, J., 2005. Improving midwifery practice: the American College of Nurse-Midwives' Benchmarking Project. J. Midwifery Women Health 50 (6), 461–471. https://doi.org/10.1016/j.jmwh.2005.06.007.

De Rosis, S., Cerasuolo, D., Nuti, S., 2020. Using patient-reported measures to drive change in healthcare: the experience of the digital, continuous and systematic PREMs observatory in Italy. BMC Health Serv. Res. 20, 315. https://doi.org/10.1186/s12913-020-05099-4.

DeVlieger, R., Goemaes, R., Laubach, M., 2021. Perinatale gezondheid in Vlaanderen. Jaar 2020. [Perinatal Health in Flanders. Year 2020]. Studiecentrum voor Perinatale Epidemiologie (SPE).

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., Barry, M., 2012. Shared decision making: a model for clinical practice. J Gen Intern Med 27 (10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6.

Escuriet, R., White, J., Beeckman, K., et al., 2015. Assessing the performance of maternity care in Europe: a critical exploration of tools and indicators. BMC Health Serv. Res. 15, 491. https://doi.org/10.1186/s12913-015-1151-2.

Ettorchi-Tardy, A., Levif, M., Michel, P., 2012. Benchmarking: a method for continuous quality improvement in health. Healthc Policy 7 (4), e101–e119.

Fontein-Kuipers, Y., van Beeck, E., Kammeraat, L., Rutten, F., 2019. The woman-centeredness of various Dutch maternity service providers during antenatal and postnatal care. Int. J. Childbirth 9 (2), 92–101. https://doi.org/10.1891/2156-5287.00.00.1.

Goemaes, R., Beeckman, D., Verhaeghe, S., Van Hecke, A., 2020. Sustaining the quality of midwifery practice in Belgium: challenges and opportunities for advanced midwife practitioners. Midwifery 89, 102792. https://doi.org/10.1016/j.midw.2020.102792.

Harrison, R., Walton, M., Manias, E., Smith-Merry, J., Kelly, P., Iedema, R., Robinson, L., 2015. The missing evidence: a systematic review of patients' experiences of adverse events in health care. Int. J. Qual. Health Care 27 (6), 424–442. https://doi.org/10.1093/intqhc/mzv075.

Helsloot, K., Walraevens, M., 2015. Een Vlaams model van kwalitatief hoogstaande postnatale zorg. Ontwikkelen van kwaliteitsindicatoren vanaf ontslag uit het ziekenhuis. [A Flemish Model of High Quality of Postnatal Care from Discharge to Home]. Ugent.

Kelly, N., Blake, S., Plunkett, A., 2016. Learning from excellence in healthcare: a new approach to incident reporting. Arch. Dis. Child 101 (9), 788–791.

Krausé, S.S., Minnie, C.S., Coetzee, S.K., 2020. The characteristics of compassionate care during childbirth according to midwives: a qualitative descriptive inquiry. BMC Pregnancy Childbirth 20, 304. https://doi.org/10.1186/s12884-020-03001-y.

Krol, M., de Boer, D., Delnoij, D.M., Rademakers, D.J.M., 2015. The Net Promoter Scores—an asset to patient experience surveys? Health Expect. 18 (6), 3099–3109. https://doi.org/10.1111/hex.12297.

Kuipers, Y.F., van Beeck, E., van den Berg, L., Dijkhuizen, M., 2021. The comparison of the interpersonal action component of woman-centred care reported by healthy pregnant women in different sized practices in the Netherlands: a cross-sectional study. Women Birth 34 (4), e376–e383. https://doi.org/10.1016/j.wombi.2020.08.002.

Kuipers, Y.J., Thomson, G., Goberna-Tricas, J., Zurera, A., Hresanová, E., Temesgenová, N., Waldner, I., Leinweber, J., 2023. The social conception of space of birth narrated by women with negative and traumatic birth experiences. Woman Birth 36 (1), e78–e85. https://doi.org/10.1016/j.wombi.2022.04.013.

Kwee, J., McBride, H., Rossen, L., 2020. Quality maternal health care from the voices of childbearing women: factors that optimize and disturb wellbeing. J. Prenat. Perinat. Psychol. Health 34 (3), 171–190.

López, A., Detz, A., Ratanawongsa, N., et al., 2012. What patients say about their doctors online: a qualitative content analysis. J Gen. Intern. Med. 27, 685–692.

Mannava, P., Durrant, K., Fisher, J., Chersich, M., Luchters, S., 2015. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. Glob. Health 15 (11), 36. https://doi.org/10.1186/s12992-015-0117-9.

Ockenden D. (2022). Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services At The Shrewbury and Telford Hospital NHS Trust. Our final report. HC 1219.

Rijnders, M., Baston, H., Schonbeck, Y., van der Pal, K., Prins, M., Green, J., Buitendijk, S., 2008. Perinatal factors related to negative or positive recall of birth experience in women 3 years postpartum in the Netherlands. Birth 35 (2), 107–116.

Robert, G., Cornwell, J., 2013. Rethinking policy approaches to measuring and improving patient experience. Health Serv. Policy 18 (2), 67–69. https://doi.org/10.1177/1355819612473583.

Schoonenboom, J., Johnson, R.B., 2017. How to construct a mixed methods research design. In: Kolner. Z Soz. Sozpsychol., 69, pp. 107–131.

Schulz, A.A., Wirtz, M.A., 2020. Midwives' empathy and shared decision making from women's perspective—sensitivity of an assessment to compare quality of care in prenatal and obstetric care. BMC Pregnancy Childbirth 22, 717. https://doi.org/10.1186/s12884-022-05041-y.

Statbel. (2022). Diversiteit naar herkomst in Belgie. [Diversity of Background in Belgium. 2022]. https://statbel.fgov.be/nl/themas/bevolking/herkomst Accessed 3 October 2022.

Statistics Flanders. (2022). Flander in figures. Statistics Flanders.

Torres, E., Vasquez-Parraga, A.Z., Cristobal Barra, C., 2009. The path of patient loyalty and the role of doctor reputation. Health Mark. Q. 26 (3), 183–197.

Waldenström, U., 2004. Why do some women change their opinion about childbirth over time? Birth 31 (2), 102–107. https://doi.org/10.1111/j.0730-7659.2004.00287.x.

Willmington, C., Belardi, P., Murante, A.M., Vainieri, M., 2022. The contribution of benchmarking to quality improvement in healthcare. A systematic literature review. BMC Health Serv. Res. 22, 139. https://doi.org/10.1186/s12913-022-07467-8.