Untangling the elements of midwives' occupational wellbeing

Liesbeth Kool

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A study among newly qualified and experienced midwives

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COLOFON

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"Science is the art of differentiation. Discovering in every man that which distinguishes him from others is to know him."

- Hermann Hesse, 1930

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CHAPTER 1

General introduction

This thesis deals with the occupational wellbeing of midwives in the Netherlands with a focus on newly qualified midwives (NQMs) and their transition into practice. In this introductory chapter, the concept of occupational wellbeing is explained, including the current situation of the art of occupational wellbeing of midwives. Furthermore, the work environment of midwives in the Netherlands is described, particularly of NQMs. This chapter concludes with the overarching problem statement for this thesis, related research questions, and an outline of the thesis.

Midwives' occupational wellbeing

Wellbeing is defined as: 'When individuals have the psychological, social, and physical resources they need to meet a particular psychological, social, and/or physical challenge.'[1] Occupational wellbeing is defined as a broad construct that includes individual and organizational factors that interact and lead to the well-being of employees.[2] Occupational wellbeing results in a spectrum ranging from positive feelings of autonomy, satisfaction, competence at one end, and negative aspects of work resulting in anxiety and low well-being at the other end.[2,3] Occupational wellbeing in healthcare research is often characterized one-sidedly by the prevalence of burnout,[4] stress, depression, and anxiety.[5] Other measured variables of midwives' well-being are job strain and intentions to leave the profession.[6-8] Occupational wellbeing consists of two different independent processes, a motivational process and a health impairment process, both with different outcomes.[9] On the one hand, the health impairment process leads to burnout and negative performance, and on the other hand, the motivational process leads to work engagement and positive performance.[9]

The literature mainly reports two different constructs of positive wellbeing: job satisfaction and work engagement.[9,10] Although job satisfaction and engagement are both positive states of mind, engaged professionals are proactive and more driven in their work than satisfied professionals.[11] Work engagement is also more related to work performance than job satisfaction.[11] Work engagement is defined as: 'a positive, fulfilling, work-related state of mind that is characterized by vigour, dedication to the work, and by absorption'.[10]

Although research on positive wellbeing within the midwifery profession is scarce, outcomes have been reported on job satisfaction or intentions to stay in the profession.[12-15] These studies among midwives show that high levels of job satisfaction are associated with less turnover and absenteeism. Satisfied midwives enjoyed the type of work and did not want to leave their job.[16] Contributing factors to midwives' job satisfaction are positive collaborations with colleagues, having meaningful work content, autonomy at work, and a manageable workload.[12,17] A few small studies on midwives'

wellbeing reported on work engagement.[18,19] Midwives showed high levels of work engagement, and determinants of work engagement were working with pregnant individuals and their families, which is perceived as meaningful work. Studies on other professions and occupations show that working with clients, autonomy, and social support are associated with high work engagement.[20] As well as occupational determinants, personality traits such as self-esteem, self-efficacy, optimism, and proactive behaviour are associated with high work engagement.[21,22]

Negative wellbeing among midwives is often operationalized in burnout symptoms.[5] International research shows that work-related burnout among midwives ranges between 20 and 60 per cent.[5,23] Determinants of burnout include a low maturity level, being young, not much work experience, and being single.[5] Furthermore, a lack of staff, low salary, poor professional recognition and organization, and a negative work environment contribute to burnout symptoms among midwives.[5]

On the other hand, findings in midwifery research show factors in the work which protect against burnout symptoms.[5] These factors include working with pregnant individuals, supportive relationships with colleagues, and working with like-minded fellow midwives.[6] Furthermore, personal resources, which were referred to in the previous paragraph as contributing to high work engagement, also protect against burnout symptoms. These factors are self-esteem, self-efficacy, optimism, and proactive behaviour. [21,22]

Transition-into-practice

Occupational wellbeing of newly qualified midwives (NQMs) is related to their transition-into- practice experiences.[24] Transition-into-practice for newly qualified health professionals is viewed as 'a foundational period of time, at the start of a career, whereby a newly qualified practitioner can build competence and confidence as an autonomously working professional'.[25] For midwives, this marked period from graduation as a midwife towards working as a registered midwife is regulated and legislated.[25] In countries such as the United Kingdom and Australia, NQMs are required to complete a period of supervised working in practice before being permitted to work autonomously with pregnant women.[25] In other countries such as New Zealand, Canada, and The Netherlands, NQMs are registered immediately after graduation and able to work in practice autonomously: providing care across the entire scope of midwifery practice.[24] In contrast to other countries,[24-26] transition-into-practice experiences of NQMs in the Netherlands have not yet been studied. Transition- into-practice in midwifery research seemed to depend on the work environment NQMs choose to work in.[24] In hospital settings, NQMs learn to evaluate and assess risks, and they are socialized to work as an efficient and effective team member within an institution rather than working 'with the

women'. In a community setting, however, NQMs face a sense of responsibility which induces anxiety around the decisions they make in practice. On the other hand, working in the community while working in continuity of care also provides NQMs with the benefits of building relationships with the pregnant individuals, of being 'with the women' as a midwife.[24]

Transition support

Research suggests that the importance of transition support for NQMs is beneficial for NQMs.[24] Transition support in the hospital setting helps NQMs navigate between the expectations of the profession and the realities of working in a medicalized model of care within a hospital. [24,27]In the community, transition support helps NQMs to feel a sense of belonging in a small team with fellow midwives and enables them to work in continuity of care.[24,28] Furthermore, national transition-into-practice programmes for NQMs were implemented to guarantee safe midwifery care.[25] Transition support addresses issues regarding NQMs' feelings of lacking competence and confidence while working in practice, and strengthens their experience with uncomplicated pregnancies and births.[29] Hospital-based transition-into-practice programmes prepare NQMs to work with pregnant individuals who face complications and higher risks in their pregnancy.[24] From a broader perspective, supporting the transition of newly qualified healthcare professionals (NQPs) seems effective. Transition support increases NQP's level of confidence and competence in practice, increases job satisfaction, reduces stress, and increases retention rates.[30-32] Research shows that effective transition support consists of different components, a combination of classroom instruction, observational experience, coaching, and computer-based learning alongside well-prepared and supported mentors.[30-34] For an effective transition-into-midwifery practice, fellow midwives seem to be pivotal. They can offer a supportive work environment and also offer mentorship.[35]

The work environment of midwives in the Netherlands

Midwives working in the Netherlands can choose between two different work environments: in a community or in a hospital setting. Most of the NQMs (72%) start their career as a locum midwife in the community (see textboxes: The organization of midwifery care in the Netherlands and Midwifery education in the Netherlands).[36] A minority of NQMs work as an employed hospital-based midwife (7%).[36] A registered midwife working in the community setting is responsible for the continuity of care for pregnant women and their partners, and for risk assessment. When problems arise, she will refer women to secondary care. In the hospital setting, a midwife works partially autonomously, in decision-making and in providing low-risk midwifery care, and partially

under supervision of an obstetrician. In medium and high risk-situations, the midwife decides whether and when to involve the obstetrician.

As an illustration of NQMs, we created two different personas in the text below: Mirthe, a community-based NQM and Annabel, a hospital-based NQM.

Mirthe is a 25-year-old NQM raised in a suburban region in the Northern part of the Netherlands. She recently graduated as a midwife and used to live in the city of Groningen. She now lives with her partner in the region where she was born and raised. Before graduation, she expected to work as a member of a community practice close to her friends and family. In reality, she is working as a locum midwife for three different practices, one of which is near her own home. When she is on-call she cannot always sleep in her own bed. While working, she enjoys the work with pregnant women, and meeting her fellow midwives. She finds it hard not to think about her work during her time off. She is constantly rethinking her decisions. Because of the different practices she works for, she finds it difficult to make connections with colleagues in the area and with the hospital's collaborators. She also finds it difficult to work in different regions: each region has its own protocols. She also has no guarantees about the number of shifts she will be hired for in the upcoming months. Currently, she feels a bit disappointed about the conditions in which she has to work as a locum midwife.

Annabel is currently working as a hospital-based midwife in a teaching hospital in the Randstad, the most densely populated area in the Netherlands. She works in a team with 15 fellow midwives. She chose to work in the hospital for the challenges in the work: complexity of midwifery care, working in a multidisciplinary team and working according to a timetable. Working 8 or 12-hour shifts is a work condition that she prefers. Annabel is 29 years old, recently graduated as a midwife, and previously obtained a Master's degree in English literature. Before graduation, Annabel expected to work alongside fellow midwives. She was expecting to learn and develop herself as a midwife by sharing experiences. Her team members value her for her openness to learning and developing as a midwife and for her social skills. They describe Annabel as a nice person who can 'talk to anyone'. Currently, she is a little disappointed with her work. Colleague midwives are usually not available to discuss cases. She also finds it difficult to work in the different roles that are expected of her in the hospital. She likes working in a team, but it is difficult to feel she belongs because she always has her temporary employment contract in the back of her mind.

Problem statement

NQMs' wellbeing and performance in practice in the Netherlands is unknown, due to a lack of existing research about this topic.[24] International research on NQMs is hard to generalize for the Dutch work environment, because these studies mainly focus on hospital-based midwifery.[24] Assumptions are made in previous research that NQMs in the Netherlands tend to avoid risks and that the care they provide might be substandard.[37] International research indicates that midwives who prefer to be 'on the safe side' might initiate more premature interventions ('too much too soon').[38] Moreover, overuse of interventions leads to unnecessary risks for pregnant women and higher healthcare costs.[38]

Healthcare workers' wellbeing is important because their wellbeing is an important indicator of the quality of care provision and the healthcare system in general.[39] Burnout, psychological distress, and poor social resources are associated with suboptimal patient care, unprofessional conduct, and leaving the profession.[39] The importance of work engagement and its contribution to performance in practice and professionals' wellbeing is shown for various occupational groups but data about midwives is lacking.[20]

Previous research on NQMs suggest that they lack self-confidence and doubt their own competence, which has implications for their wellbeing and performance in practice.[24,40] NQMs meet different challenges in their chosen work environment.[25] For instance, NQMs have to become a trustworthy member of the monodisciplinary and multidisciplinary team and have to work as a member of the profession.[27] Furthermore, NQMs experience a theory-practice gap, and have to work according to job expectations. When these expectations do not meet their own values, NQMs experience anxiety, stress, and attrition from the job.[27,41-43] Research on NQPs who work in independent practices indicates that this environment creates barriers to asking for help from colleagues, which affects their performance in practice.[44] Furthermore, the importance of a supportive team and positive support from fellow midwives in the transition-into-practice is highlighted in previous research. [24,26,29]

Knowledge gaps

Research on midwives' occupational wellbeing in the Netherlands is outdated. Data on burnout levels date back to 1996.[45] Internationally, research on occupational wellbeing of midwives primarily focuses on negative wellbeing: burnout symptoms.[5] There is a lack of knowledge on the positive wellbeing of midwives and its determinants in the hospital and in the community settings.[18] How the specific work environment of NQMs in the

Netherlands (with greater accountability and working alone) contributes to their wellbeing has not yet been studied.

There is also no previous research about NQMs' transition-into-practice in the Netherlands and how they perceive their work from the point of graduation as a registered and accountable midwife in practice. Due to the independent and autonomous work of NQMs in the Netherlands, often without the resources of nearby fellow midwives, it is not known how they perceive their transition-into-practice.[24,44] Furthermore, it has not been previously studied how stakeholders in midwifery care in the Netherlands perceive the importance of supporting NQMs and what they perceive as applicable in the current organization of midwifery care.

Aim of this thesis and research questions

Therefore, this thesis aims to provide knowledge about 1) the occupational wellbeing of NQMs in practice, 2) the transition-into-practice experiences of NQMs, and 3) how to support this transition period in practice. As research shows that NQMs in practice need supportive fellow midwives for self-confidence and feelings of competence in practice,[24,26] we also studied experienced midwives' wellbeing, their perceptions on supporting NQMs, and whether they have intentions of leaving the profession.

Research questions within this thesis are:

1. How do NQMs perceive their transition-into-midwifery practice, and how is this transition supported in practice?
2. What are the levels of wellbeing of NQMs and of experienced midwives in the Netherlands, and which determinants are associated with wellbeing and intentions to leave the practice?
3. What are the desired and the feasible components of support of the NQMs' transition-into-practice?

With these studies, we aim to contribute to the knowledge of midwives' occupational wellbeing and the importance of adding positive wellbeing to the knowledge of midwives' wellbeing internationally. With this knowledge, the midwifery profession can identify the work-related factors associated with positive wellbeing and make changes in the organization of midwifery care according to these factors. Furthermore, this thesis contributes to knowledge about the transition-into-practice experiences of community-based NQM midwives and their wellbeing. With this new knowledge, we aim to contribute to the professional wellbeing of NQMs and, ultimately, to their performance in practice and overall contribution to the required quality of midwifery care. Without this knowledge, it is impossible to gain a thorough picture of the wellbeing and performance of NQMs in community-based practice in particular.

Theoretical model

For this thesis, the Job demands and Resources (JD-R) theory is used as a theoretical framework for multiple reasons. First, this model is based on a comprehensive approach to employee wellbeing, with integrated intrinsic and extrinsic factors and their impact on outcomes.[46] Second, the JD-R model is a heuristic model that helps identify the specific demands and available resources in a specific occupation.[22] Third, the JD-R model is based on the premise that employee wellbeing is the result of the balance between workload and resource availability at work.[47] Knowledge of midwives' occupational wellbeing and its determinants can be developed through the research on the influence of specific job characteristics and personal characteristics, as identified in the specific work environments.[9,47] Occupational wellbeing in the JD-R model (figure 1) is based on two different constructs: burnout and work engagement.[10] High work engagement, a result of a motivational process, is associated with better mental and physical health, better work ability, and is beneficial for work performance and workplace safety.[20] Burnout is a health impairment process in which professionals deplete their energy resources, leading to reduced involvement with the work, and with the clients.[47]

Job demands (JD) are aspects of the job requiring effort and are associated with mental or physical costs.[47] Job resources (JR) help professionals to achieve job goals or to reduce job demands.[47] Personal resources (PR) are positive self-evaluations that are linked to resilience and refer to an individual's sense of being in control and the ability to impact their environments successfully.[48] Personal resources contribute positively to wellbeing, and they can also initiate an upward spiral of resources that reinforce each other, resulting in higher work engagement.[48] Furthermore, personal resources are mediators for the health impairment process, reducing the development of burnout symptoms.[22,48]

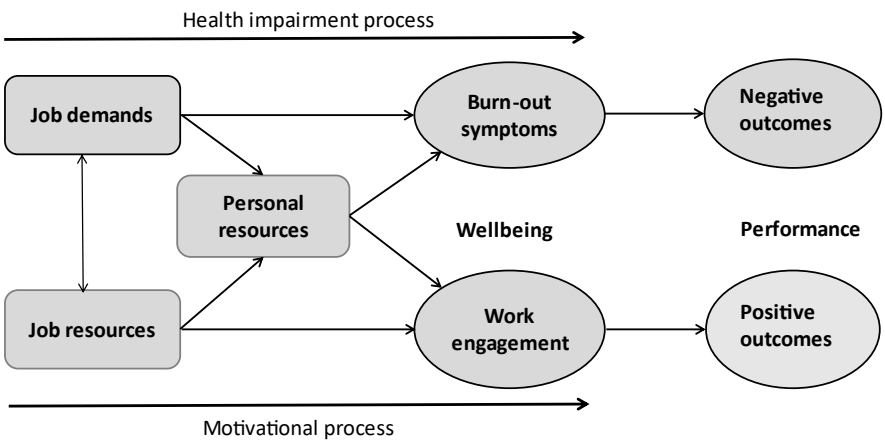

Figure 1. Adapted JD-R model[22]

Outline of this thesis

The overview of the studies in this thesis is presented in Figure 2, based on the JD-R model. In chapter two and three, we answer the first research question. We identify job demands, job resources, and personal resources, which affect occupational wellbeing and performance of NQMs in community-based midwifery (Chapter 2) and among hospital-based NQMs (Chapter 3).

In chapter four, we report on a quantitative study on the occupational wellbeing of midwives in the Netherlands and the determinants associated with wellbeing. We answer the third research question by measuring work engagement (WE) and burnout symptoms (BO) among midwives in the Netherlands. Furthermore, we identify the work characteristics and personal characteristics associated with wellbeing (WE and BO) among midwives: NQMs and experienced midwives. In chapter five, we explore midwives' intentions to leave and reasons to leave the profession as a midwife. Furthermore, reasons leading to leaving the profession were qualitatively explored.

In chapter six, we identify the perceptions of experienced midwives regarding NQMs in the workplace. We explore the views of midwives on supporting NQMs in practice. Chapter seven includes a study on feasible components of support for NQMs' transition-into-practice by exploring maternity care stakeholders' commitment to important and applicable components of support for NQMs.

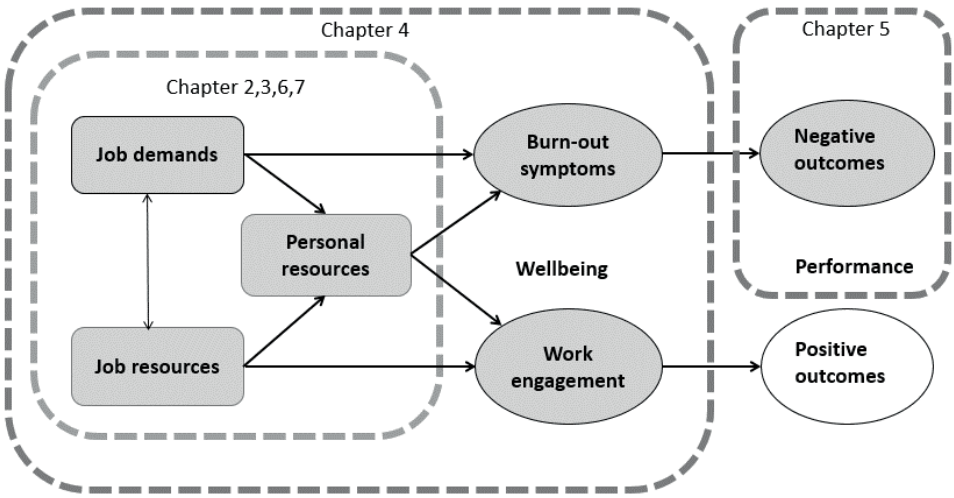

Figure 2. JD-R model in chapters and research questions in this thesis

The organization of midwifery care in the Netherlands

Historically, the scope of midwifery in the Netherlands is related to the law of 1865.[49] This law legislated midwives only to attend deliveries that were the work of nature and forbade midwives to attend 'abnormal' deliveries.[50] This tradition was common practice until the 1960s.[50] From the 1970s, women began to prefer choosing where to deliver their children: in a hospital or at home. Therefore, outpatient births were introduced, where women give birth in a hospital accompanied by their primary care midwife and are discharged within 24 hours after birth. Furthermore, hospitals also employed midwives in a hospital setting to enhance physiology in medically indicated births.[50]

Midwives in the Netherlands are trained to work autonomously in maternity care.[51] The majority of Dutch midwives work in the community (72%).[52] They are also responsible for risk-level selection: whether women should be referred to an obstetrician based on the Obstetric Indications List (VIL). Community-based midwives mainly work self-employed in a (group) practice in the community. They work as equal partners and hire locum midwives to cover for holidays, maternity, or sick leave. A minority of midwives (7-13%) work in secondary care in a hospital setting. They are responsible for women with medium and high-risk pregnancies.[52] In the hospital setting, the tasks and responsibilities between obstetricians and clinical midwives are divided, with midwives being autonomously responsible for some tasks according to strict protocols and working under supervision of an obstetrician for others.[53] Hospital-based midwives are in charge of the delivery rooms most of the time and delegate some tasks to obstetric nurses. They bridge the gap between primary-care midwives and obstetricians.[53] In the Netherlands, a trend over the last decades is that NQMs work as a locum midwife (72%) and a minority work as a partner in a community practice (4%).[36] Until 2005, these percentages were different: 0-5% of the NQMs worked as a locum, and 20-45% worked as a partner in a midwifery practice or hospital-based (10-25%) or were not working as a midwife (20-60%)[36]Job-seeking midwives largely wanted to work in a partnership in a community-based midwifery practice (58%).[36]

Midwifery education in the Netherlands

Students are educated in a four-year direct-entry midwifery programme at a university of applied sciences. Three different universities offer a Bachelor of Science midwifery programme, and 220 students start the programme annually. The inflow of student midwives is regulated by the government through a numerus fixus (a restriction of the number of places on offer on popular and costly degree programmes).[51] The professional

education of midwives in the Netherlands prepares students for a full qualification. They are allowed to register themselves as a midwife after graduation.[54] The regulation of the educational programme at a national level is laid down in an Order of Council Midwifery.[55] Due to the inflow of midwifery students in the Netherlands being limited by the government, there is also an influx of NQMs who are educated in other countries. Midwives with a bachelor's degree in midwifery obtained in another European Union Member State can practice as a midwife in the Netherlands. Twenty per cent of all practicing midwives in the Netherlands were educated abroad.[36] Most of them were educated in Belgium. Belgian midwifery students are also trained to be independent professionals in the care of women with uncomplicated pregnancies.[56] However, they are mainly trained in a hospital setting. Therefore, Belgian midwifery students do not acquire all the professional competencies and autonomy they need to work in the community.[56] For a Master of Science degree, midwives are dependent on generic Master of Science programmes in research or health sciences. In 2023 a Master midwifery programme started at national level, provided by a collaboration between all universities with a bachelor of midwifery programme. PhD tracks have been developed at the midwifery academies in cooperation with other universities.

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CHAPTER 2

Perceived job demands and resources of newly qualified midwives working in primary care settings in the Netherlands

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ABSTRACT

Objective: The objective of this study is to identify perceived job demands and job resources of newly qualified midwives (NQMs), working in primary midwifery care during their first years in practice.

Design/Setting: A qualitative study, with semi-structured group interviews was conducted. Midwives working less than three years in primary midwifery care in the Netherlands were invited to join a focus group interview.

Measurements and findings: Five focus group interviews were conducted with 31 participants. Interviews were transcribed and analyzed. Data were analyzed thematically by using the different characteristics of the Job Demands Resources model. Working as a locum midwife is demanding for Dutch NQMs, due to a large number of working hours in different practices and a lack of job security. Decision-making and adapting to local guidelines and collaborations demand a high cognitive load. These aspects of the work context negatively impact NQMs' work and private life. Working with clients and working autonomously motivates the newly graduates. Support from colleagues and peers are important job resources, although colleagues are also experienced as a job demand, due to their role as employer. Strictness in boundaries, flexibility and sense of perspective are NQMs' personal resources. On the other hand, NQMs perceived perfectionism and the urge to prove oneself as personal demands.

Key conclusions and implications for practice: Dutch NQMs' first years in primary midwifery care are perceived as highly demanding. In primary care, NQMs usually work as locum midwives, self-employed and in different practices. Working in different practices requires not only working with different client populations and autonomous decision-making, but also requires adaptation to different local working arrangements. Building adequate support systems might help NQMs finding a balance between work and private life by having experienced midwives available as mentors. Furthermore, training and coaching of NQMs help them to become aware of their personal resources and demands and to help them strengthen their personal resources. Improving NQMs' working position through secure employments require changes in the organization of maternity care in the Netherlands.

INTRODUCTION

Performing as a newly qualified midwife (NQM) in midwifery practice is challenging and demanding.[1] Newly qualified midwives are fully responsible and accountable for providing care to their clients from the moment of graduation (or registration).[2] International research shows that the weight of responsibilities in the first year of practice can negatively influence NQMs' professional confidence as well as the overall quality of the provided care.[3,4]

Further to the outcomes of international research studies, NQMs in the Netherlands are likely to face a number of additional challenges due to the specific Dutch context. First, in Dutch primary midwifery care, midwives work independently in providing pre- and postnatal care, and during labor and birth. The primary care midwife is the professional in charge for low–risk pregnant women.[5] Second, NQMs in other countries are supported in their transition from student to registered midwife.[1,6,7] In the Netherlands, formal support programs for NQMs do not exist. Third, in the Netherlands 72 percent of NQMs work as a locum midwife (explained in textbox 1) in primary care during their first years in practice,[8] as opposed to most other developed countries, where NQMs are usually employed by a hospital and work in a hospital setting.[1,6,9]

Within the Dutch midwifery care system, primary care midwives refer pregnant women to obstetricians when complications arise. Over the past decade, referral rates have been increasing which could partly be attributed to midwives' attitudes due to feelings of insecurity and anxiety.[10] These increasing referral rates could threaten in the long term the unique choice for women in the Netherlands to give birth at home.

Primary care midwifery practices hire a locum midwife to cover for holiday, maternity or sick leave. Locum midwives are self-employed. In order to be recognized as self-employed ("autonomous professional without personnel") by the Dutch tax agency, locum midwives are required to work for a number of different midwifery practices, to demonstrate their in- dependence.[11]

International studies on NQMs show that factors such as reality shock,[12] applying a different midwifery philosophy of care,[13,14] and delay in securing employment and work allocations make the first years a very demanding period for NQMs.[15] Studies on work resources for NQMs show that positive support and mentorship from colleagues,[1,15] working in continuity of care models,[16,17] and postgraduate preceptorship programs are associated with increasing confidence and competence.[1,14]

International research shows a gap in knowledge about the specific work and personal characteristics of NQMs.[1] Also, as stated earlier, Dutch primary NQMs' working circumstances differ from NQMs in other countries. Therefore, the aim of this study is to identify perceived job demands, job resources and personal resources by NQMs working in primary midwifery care during their first years in practice.

METHOD

A qualitative descriptive design was used for this study. Data were collected through focus group interviews with NQMs. For reporting this study, we used the COREQ checklist.[18]

The Job Demands-Resources (JD-R) model[19] was used as a theoretical framework (figure 1) to identify the specific work-related demands and resources in primary midwifery care. The JD-R model was developed in the early nineties of the twentieth century,[19] and has been widely used for different (healthcare) professions, which allowed us to compare our results with other professions and occupations.[20] The JD-R model describes the relationships between job and personal characteristics as two intertwined processes: 1) the motivational process, leading to work-engagement and 2) the stress process, leading to exhaustion and burnout. The JD-R model is based on the assumption that, although work characteristics differ for various occupations and professions, they can be modelled in two categories: job demands and job resources. Contrary to other models, the JD-R model permits the incorporation of many possible working conditions, depending on the specific working context.[20] In addition to work characteristics (job demands and job resources), personal resources were integrated in this model.[21,22] In this study we only used elements of the JD-R model, to identify job demands, job resources and personal resources that are relevant for NQMs. We did not use the other components of the JD-R model (exhaustion and work engagement) in this study.

Job demands are aspects of the job requiring effort and are associated with mental or physical costs, for example work overload, heavy lifting or job insecurity. Job resources help the professional achieve job goals or reduce job demands, such as feedback, job control or social support. Personal resources help employees in achieving goals, such as resilience, optimism, flexibility and self-confidence.[20]

Participants were NQMs, less than three years after graduation and working in primary midwifery care in the Netherlands. Participants were recruited from course participant lists from continuous professional development (CPD) courses, organized by all four midwifery academies in the Netherlands and from alumni of cohort 2016 of the midwifery academy Groningen. From the participant lists, which included year of

graduation, we invited eligible midwives by email. All selected NQMs were willing to participate in a focus group interview. The ones that were able to join a scheduled focus group interview, participated in the study.

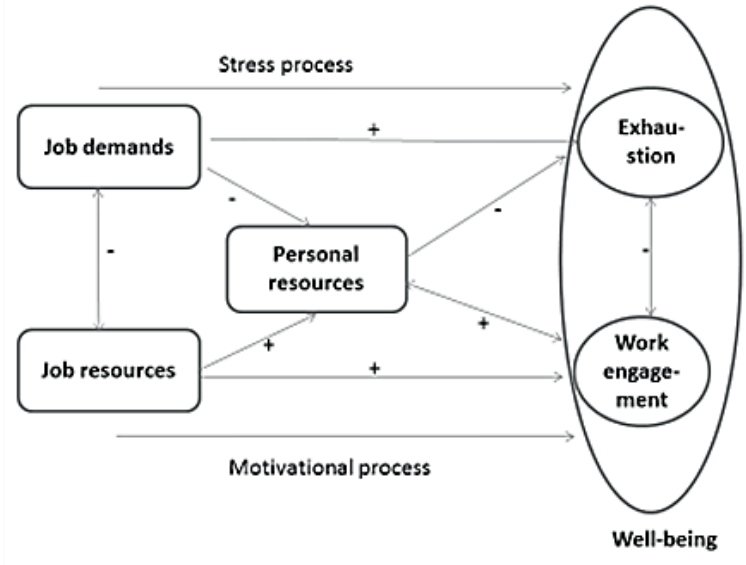

Figure 1. Theoretical model the Job Demands-Resources model.[19]

We conducted five focus group interviews, with four to ten NQMs each. Focus group interviews were conducted until data saturation was reached. The interview questions were based on a topic guide (see appendix A) which was derived from previous literature on NQMs and the JD-R model.[19,20,22] Four focus group interviews (A-D) took place after a CPD course, where the participants were recruited. One focus group interview (E) was held as a stand-alone event at the midwifery academy in Groningen. The interviews were facilitated by trained moderators and observed by a researcher or research student. The observer took the audio recordings and notes. All participants were first asked to sign a consent form, and then answer four questions on paper about their first period in practice (see appendix B). The moderator started the group discussion by inviting participants to share their notes with the group members. The moderator asked questions for further explanation and invited all participants to join the discussions. In the fourth and fifth focus group interviews, categories and themes from the first analysis were added as input at the end of the interview session. Participants were asked if they recognized themselves in the specific categories and themes. As interviews four and five did not yield any new information from participants, data saturation was assumed to have been reached. The interview records were transcribed.

MAXQDA (11.0) was used to analyze data. The transcribed interview content was analyzed thematically. After three focus group interviews, two researchers (LK, EF) conducted a first analysis. They individually coded the data, underlined text fragments, and both created interpretive codes. Categories were identified for similar codes. The researchers then compared and discussed the categories until they fully agreed. Subsequently, categories were labeled, using the aspects of the JD-R model: job demands, job resources and personal resources. For example, the code: 'working with other health care providers costs energy', was labelled as 'colleagues' and identified as a Job Demand. Additional themes were added when labels did not match the themes. For example, 'personal demands' was added as a new theme. After focus group interviews four and five, the researchers coded, categorized and labelled data from the fourth and the fifth interview transcripts as previous interviews.

In line with legal requirements in the Netherlands (www.ccmo.nl) medical ethical approval was not necessary. However, we asked all participants for written informed consent. Confidentiality was guaranteed with anonymous reporting of the data by numbering the interviews and participants. Raw data were saved securely at the University of Groningen. Written consent forms as well as the transcribed interviews are stored and available upon request.

RESULTS

The duration of the five focus group interviews ranged between 45 and 75 minutes. Fifty-one NQMs agreed to take part with 32 finally being able to participate in focus group interviews. One participant did not meet the inclusion criterion of being less than three years graduated. The data of this participant in the focus group interview were deleted from the transcripts before the analyses. In total, data of 31 female midwives were analysed, with a mean age of 26 years (range 23 – 44). All participants worked in primary midwifery care in the Netherlands. Five (16%) graduated from universities in Belgium and the remainder from academies in the Netherlands (84%, n=26). The majority of the participants worked as a locum midwife (71%, n=22) in different practices, eight midwives worked as an employed midwife (26%, n=8), and one participant was self-employed as partner in a midwifery practice. Nearly half of the participants worked in an urban area (45%, n=14); the other half of the participants worked in a rural environment (39%, n=12) or in both an urban and a rural area (13%, n=4).

Table 1. Background characteristics of participants (N=31)

Characteristics		**N (%)**
Midwifery Academy	Amsterdam	7 (23)
	Groningen	9 (29)
	Maastricht	4 (13)
	Rotterdam	6 (19)
	Belgium	5 (16)
Year of graduation	2013	2 (6)
	2014	10 (32)
	2015	12 (39)
	2016	7 (23)
Employment	Locum	22 (71)
	Employed	8 (26)
	Partnership	1 (3)
Work context	Urban	14 (45)
	Rural	12 (39)
	Rural/Urban	4 (13)
	Other	1 (3)

The results are presented in figure 2, using the themes of the JD-R model: job demands, job resources, personal resources and an additional theme: personal demands. In the analysis we used examples of categories within the themes, according to the job demands and resources from Schaufeli and Taris,[20] for example work overload, job insecurity, and time pressure as job demands; and positive client contacts, task variety and autonomy as job resources.

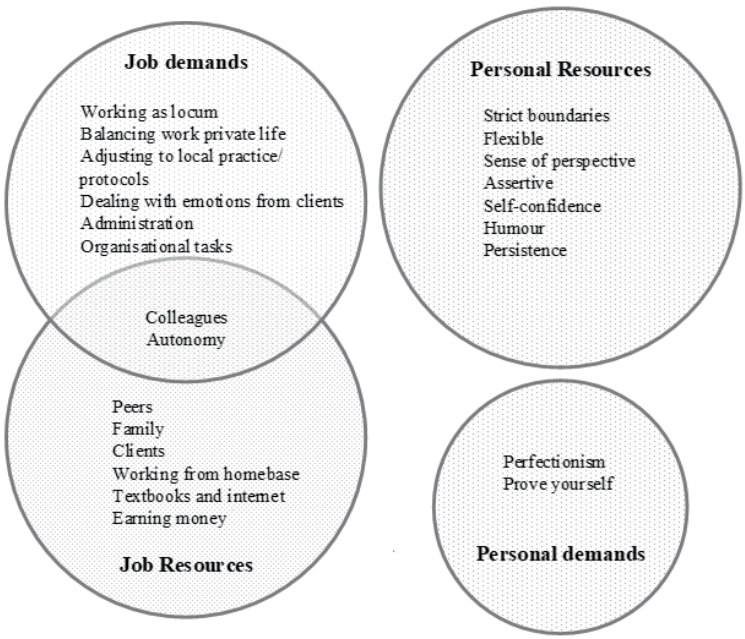

Figure 2. Job demands, job resources and personal resources experienced by Dutch primary care midwives (N=31)

Job demands

Important job demands (figure 2) are working as a locum midwife, balancing work and private life, adjusting to local practice and protocols, dealing with emotions from clients, and administrative and organizational tasks. Working as a locum midwife was experienced as highly demanding. NQMs faced unexpected challenges, such as the number of shifts they have to work on a fulltime basis and working shifts in different practices. On the one hand, employers expected flexibility from NQMs, as they needed the locum midwife to fill a gap in the work schedule. NQMs wanted to work as much as they could, so they took all the work they could get. The reasons for this were twofold: for themselves, to gain experience and, secondly, to appear employable to their employers. Participants stated that they have to learn to manage their work hours and to have sufficient time off.

Yes, you know …you have no job-security, so you take all the work you can get everywhere. And, yes, I can recall, the insecurity that belongs to locum midwifery … that increases pressure". (A1)

You want to work everywhere and therefore you will cross personal boundaries. (D5)

As a locum midwife, NQMs had to learn to get the right amount of work as well as balancing work and private life. Combining work with their private life was also mentioned as physically and mentally demanding. During on-call shifts, they had to sleep within the practice area, which affected their private life, especially for NQMs with partners and children. The irregularity in working hours also influenced leisure time activities.

When I was working, everything went all right, but when I was at home, I collapsed so to speak. Then, emotions came up, so to speak. (B1)

Colleagues were mentioned as both a demand and a resource. Support from colleagues was mentioned as a resource for NQMs, but as a locum midwife, colleagues were also their employers. NQMs worry that consulting a colleague may imply incompetency. Participants mentioned that they are aware of their colleagues' different roles.

I can deal very well with my colleagues, but sometimes when I am in doubt about a *small issue, I think: yes, I can call my colleague, but then they could think: why is this employee working for us? (D7)*

Working in different regions was mentally demanding for NQMs. They were expected to know the regional protocols and had to apply them in their decision-making. Furthermore, they had to know the different practitioners within the local communities. Managing emotional client conversations was also experienced as demanding.

…to start an emotional conversation. Because, during placements .. as supervising midwife, you do not leave that kind of responsibilities to students…. So, as a student I did not practice such difficult conversations. (B4)

Working autonomously was identified by participants as both a job demand and a job resource. Before graduation, during placements, they worked with supervising midwives. On the one hand, they felt relieved to be now working autonomously. On the other hand, participants mentioned that they had been used to working with a supervisor and after graduation they missed the company and assurance of a supervisor.

When you are facing a home delivery and eh, the maternity care assistant is nine out of ten times too late. Then you really stand alone. (A5)

Participants experienced the planning and organisation of their day-to-day work as a locum midwife as highly demanding. Administrative tasks, such as preparing invoices and writing practice reports, were new to most NQMs. Also, they had to learn to manage their time and their tasks during prenatal clinics such as telephone calls, referrals and administration within a set time schedule. Before graduation, they worked together with their supervisors on such tasks. NQMs had to develop routines in their work, before they actually managed to fit all their work into their schedules effectively.

.. I took a lot of time at home, preparing myself for the prenatal visits. Afterwards, I went to the practice and still ran out of time. Therefore there was a lot of catching up to do. (A4)

Job resources

Important job resources were support from colleagues, peers and family (as shown in figure 2). Colleagues as experts were important for sharing decision-making. Deliberating on decisions with team members helped NQMs to feel safe and confident. Sometimes the potential availability of 24/7 support was experienced as a resource.

It's just the simple approach, you may call me in the middle of the night. Having a colleague available. .. just to deliberate with them. That idea gives me confidence, you know. (B6)

Peers were important because they encountered similar difficulties. Recognition and mutual understanding were important sources of support. Family was also experienced

as an important resource for NQMs, not only for a listening ear, but also as practical facilitators for tasks such as shopping for groceries and preparing meals. NQMs mentioned 'contacts with clients' and 'working with families at home' as particularly motivating. For example, visiting families at home provided NQMs with satisfying contacts.

When I support a woman in labour…. that is why I chose this profession. Then it is easy to get out of my bed in the night. Moreover, I feel that my work is my passion, and my passion is my work. (A3)

Working from home, in this case being able to do the job while staying at home, was also perceived as a job resource, as reported by one of the participants:

…when I am working a shift, while I can work from home, it feels as being free from work. Most of the time shifts are quite busy. But just the feeling that I can eat at home, sleep in my own bed and get a shower if I want to, that makes a lot of difference… (D6)

Textbooks and internet resources were often used by NQMs during and after their shifts and perceived as job resources. Furthermore, earning money, in contrast to their last placement as student, where they did pretty much the same work without compensation, was experienced as motivating for NQMs.

Personal resources

Participants mentioned different personal traits (figure 2), which helped them in the first period after graduation. An often-mentioned personal resource was the ability to implement strict (personal and professional) boundaries. Being able to communicate availability regarding working shifts and working hours helped participants limit and manage the amount of work. On the other hand, they had to be flexible to get enough work. Assertiveness together with a sense of perspective helped NQMs during the first period in practice.

Setting boundaries on both levels: management tasks and providing care. A good midwife does not have to work seven days a week! (C3)

The ability to reflect on situations they experienced was also perceived as important resource; looking at a situation from different perspectives. For instance by thinking: "Not all situations I come across are life threatening!".

Humour and self-confidence were also seen as important resources. Humour helped NQMs to see situations in perspective and self-confidence helped them when providing care, especially when referring clients to the hospital.

I still experience humour as a coping mechanism, to help me deal with feedback or work with a demanding client. (C5)

Personal demands

Aside from personal resources, a new theme occurred. The urge to prove themselves was experienced as a personal demand rather than as a personal resource. Perfectionism was also mentioned as a personal demand.

That you wrote down a huge amount of words in a detailed text about what had happened. That other people know what you did during your shift and I always prepared myself for the upcoming shift. And before I started a consultation with a client, I read all the reports about this client.. That costed me a large amount of energy; I was exhausted. (C4).

Furthermore, participants reported that they tend to worry about their performance.

I was educated abroad. So I felt I had to prove myself, you know. .... it took a while before I had a job as a midwife in the Netherlands. And, after a while, you become insecure…I had a strong feeling that I have to prove myself. (A2)

My pitfall is that I cannot let go of the thoughts about the things I did not do right. That I continue to worry. (C1)

DISCUSSION

We found that Dutch NQMs who work in primary care, perceive working as a locum midwife as highly demanding. In particular, although NQMs felt well prepared for providing care for women, they considered themselves ill prepared for the pressures and dynamics of working as a locum midwife. The self-employed status as a locum midwife requires working in different practices and causes fluctuations in workload and (the number of) working hours. Dutch NQMs also perceive organizational aspects of the job, for example practice administration as highly demanding.

Certain aspects of the job are perceived as both a job resource and a job demand. For instance, providing care is a job demand when it comes to decision making and working with different client populations; however, NQMs also consider it a satisfying aspect (job resource) when clients indicate they are satisfied with the provided care. Colleagues, too, are important job resources for NQMs. However, colleagues are sometimes perceived as a demand as well in their role as employer. Working autonomously, too, was mentioned as job demand (sometimes scary when there is no colleague nearby) and job resource (the joy of the experience of providing care for women in a homebirth setting).

Dutch NQMs' working conditions are different, compared to NQMs from other (high-income) countries. Working in a community practice requires the NQMs to adapt to collaboration structures and organizational tasks which are specific to that practice. This relates to collaboration with different professionals in the community as well as with health care professionals in the hospital. Organizational tasks and procedures, such as making invoices and ordering supplies can also vary by practice. These working conditions are a consequence of the specific organization of maternity care in the Netherlands,[5] which requires a high level of autonomy of NQMs both in providing care and on the organizational/ administrative elements of the job.

Similar to other studies on newly qualified health care practitioners, NQMs indicated that they are lacking competence with regard to organizational aspects of the job.[23,24] In our previous study[25] among final year student midwives in the Netherlands, we found that they were aware of the importance of organizational competencies. However, after graduation, in practice, it turns out to be a demanding task. NQMs feel competent in providing client care, but regarding organizational tasks they indicated that they perform at a lower level (advanced beginner (Dreyfus' five stage model),[26] which implies limited situational perception and lack of routines. Awareness about these differences in competency levels may help both NQMs and colleagues/employers in readjusting expectations.

Two specific pressures that Dutch locum midwives face are the pressure to gain enough work and having to work in a variety of contexts. The nature of these job demands has not been described in previous studies. NQMs in previous studies were employed and did not work in different work settings at the same time.[1,17] Different work settings are highly demanding for Dutch NQMs. This is particularly felt when NQMs have to apply local and regional agreements in clinical reasoning and decision-making, and simultaneously have to communicate with their clients and other maternity care providers. This requires the processing of a high amount of information, which can lead to incomplete and ineffective information processing possibly leading to a negative effect on the provided quality of the care.[27]

Comparing job demands on NQMs with other occupations and professions in the Netherlands,[20] the job demands on NQMs show different outcomes due to the organizational setting of employed professionals. Employed professionals experience rapidity of changes in the workplace and working pressure as highly demanding. These outcomes differ from our studies on NQMs; the majority of NQMs in primary care are working as self-employed locums and do not work within an organizational context. In

our study, psychological demands appear similar to other occupations / professions in that high levels of focus and concentration is needed for the job.

Concerning job resources, some of our findings are similar to other studies. For instance, providing care for clients, birthing experiences at home,[16,17] and support from colleagues, [1,15,17] are mentioned in studies on NQMs. Support from peers, which Dutch NQMs perceive as very important, was not previously reported in other studies on NQMs.[1,15,17] In our study, peers are experienced as safe and trustworthy sources of support. Peers are seen as a resource for debriefing and for discussions on decisions rather than more experienced colleagues. The urge for peer support seemed less of a factor in other countries, where mentorship is available for NQMs.[1,7]

Our study found that colleagues and working as a team were very important job resources, similar findings to studies on other occupations in the Netherlands.[20] Furthermore, financial rewards as job resource show also similarity with our results.[20] Work and organizational resources shows differences between our study on NQMs and other occupations in the Netherlands. For instance, clear targets and roles, and alignment within the organization were not mentioned in our study.

The JD-R model as a theoretical framework is widely applied to different occupations,[20] and health professions.[21,28] To our knowledge, this model has never been used in studies on NQMs. By using the JD-R model, we identified personal characteristics which can be a resource or demand for NQMs and added personal characteristics to research on NQMs.

Being firm with one's own boundaries, being assertive, but also being flexible and adaptable helped Dutch NQMs to balance their workload and to collaborate with other practitioners in maternity care. Dutch NQMs mentioned humour and a sense of perspective as important personal resources. Compared to previous studies on NQ health professionals, we believe we have found similar results. Worrying about their professional performance and not being able to stop thinking about their work as characteristic behaviours for NQMs might be similar to the neuroticism among junior doctors as described by Teunissen & Westerman.[24] Mastenbroek et al.,[21] in their studies on junior veterinarians, found that extraversion was an important personal resource, in addition to self-efficacy and conscientiousness. The first finding seems similar to the findings of our study, whereby assertiveness, self-confidence and humour were identified as personal resources – factors which can be associated with extraversion.

Strengths and limitations

A strong aspect of this study is the use of the JD-R model. By using this theoretical model, it is possible to compare our outcomes with studies among other professions. Using group interviews instead of individual interviews is another strength of this study. During the group interviews, participants were able to reflect on the differences and similarities between their experiences with others in similar circumstances. Another strength was the background of participants in that they reflected the diversity within the NQM population. For instance, in our study, 71% of the participants worked as a locum and 26% as an employed midwife, which is similar to the entire population of Dutch NQMs.[8] By using different interviewers as facilitators we prevented bias from researchers during the interviews. Moreover, it was clear that we reached data saturation, as the last two group interviews did not yield any new insights.

A limitation of this study was that we did not include deviant cases: NQMs who had left primary midwifery care. Kenens et al.[8] show that 10% of NQMs do not work as a midwife after graduation. If we had found NQMs who had stopped working in primary midwifery care, we could have explored which factors they perceived as reasons for resigning from the job. Another limitation of our study was the focus on primary care midwives. Although 72% of NQMs work in primary midwifery care, the outcomes may not be generalizable to the whole population of Dutch NQMs. Most of the remaining 28 percent of the NQMs work as employees in a hospital setting (mean of 21% in the past 20 years) in which dynamics are different from working in primary care.[8]

Implications for practice, research and education

The findings of our study suggest that Dutch NQMs in primary care face similar challenges to other NQMs and newly qualified professionals. In addition, they face challenges that are unique to the circumstances of the Dutch maternity system. Yet, there is no formal support for them, such as available in other developed countries.

Our findings suggest that colleagues and peers are important job resources. Colleagues in primary midwifery care may have to be increasingly aware of their importance as a job resource (and, in the case of employer, as a job demand) and their influence on the wellbeing of NQMs. NQMs may need to consider organizing their own informal (peer)support system before graduation, in order to provide themselves with the necessary resources. The professional organization of midwives in the Netherlands may need to reconsider the lack of formal support for NQMs.

Enhancing the position of locum midwives, especially for NQMs, requires better employment prospects for NQMs. Most NQMs do not have a choice about the type of

employment they enter into, when working in primary midwifery care; most have to work as a locum midwife for a considerable period of time. With the outcomes of this study, the professional organization of midwives is well positioned to start a discussion within the field of maternity care regarding the specific difficulties of being a locum NQM and the employment conditions Dutch primary care NQMs face in practice.

Further studies using quantitative research designs can provide insight into the associations between different aspects and their effect on NQMs' stress, work engagement and performance. Knowledge about NQMs' work and personal characteristics can provide relevant information for building adequate support programs for NQMs which further enhances the quality of care provided by NQMs, and may also influence retention of NQMs to the profession.

With the outcomes of this study, midwifery academies in the Netherlands and Belgium can better prepare their students for the period after graduation. They can align expectations of student midwives who are about to graduate about the kind of employment they are likely to face and the reality of working as a NQM in practice. The academies can facilitate students to acquire the necessary personal resources for practice, such as assertiveness, flexibility and sense of perspective. In collaboration with the professional organization of midwives, midwifery academies may facilitate NQMs through adequate support and training.

CONCLUSIONS

Dutch NQMs' first years in primary midwifery care are perceived as highly demanding. NQMs often have to work as a locum self-employed midwife, fulfilling the sick and holiday leaves of other, more established, midwives. Job insecurity, a varying amount of working hours and working in different practices at a distance from their own homes characterise this type of self-employment. Working in different practices requires not only working with different client populations and autonomous decision-making, but also adaptation to different local arrangements. Dutch NQMs have to be competent in providing care, but on management/administrative tasks, they seem to be operating at the level of advanced beginners. NQMs' first months after graduation are overwhelming: working and thinking about getting enough work. Building support systems may help NQMs find a balance between work and private life. Support from experienced midwives can play an important role in achieving this balance.

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Appendix I Topiclist group interviews

Participant characteristics	**Work characteristics**
- Gender - Age - University - Employed / Self-employed	Job-demands • Which challenges did you encounter in practice, just after graduation? • What did you have to learn, as you experienced working in practice? • How did you experienced the job demands? • In what way was the job demanding (physical and mentally)? Job-resources • Which aspects of the job were facilitating in doing your work? • Which factors provide energy / did you experience as motivating? **Personal characteristics** Personal resources If you reflect on yourself or a peer: • Which behaviour/qualities/skills helped in the execution of your work? • Which factors helped you seek balance between work and private life? • Which pitfalls did you see in yourself or your newly graduated colleagues?

Appendix II Questions for participants

1. How did you experienced the first period in practice, after graduation (physically, mentally)?
2. What is your opinion about you performance as newly qualified midwife?
3. Which aspects of the job did you experience as hard/tough, or costed you energy?
4. Which aspects of the job provide you with energy?
5.

CHAPTER 3

The initiation of Dutch newly qualified hospital-based midwives in practice, a qualitative study

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ABSTRACT

In the Netherlands, a percentage of newly qualified midwives start work in maternity care as a hospital-based midwife, although prepared particularly for working autonomously in the community.

Aim: This study aimed to explore newly qualified Dutch midwives' perceptions of their job demands and resources during their initiation to hospital-based practice.

Design: We conducted a qualitative study with semi structured interviews using the Job Demands-Resources model as theoretical framework.

Methods: Twenty-one newly qualified midwives working as hospital-based midwives in the Netherlands were interviewed individually between January and July 2018. Transcripts were analyzed using thematic content analysis.

Findings: High workload, becoming a team member, learning additional medical procedures and job insecurity were perceived demands. Participants experienced the variety of the work, the teamwork, social support, working with women, and employment conditions as job resources. Openness for new experiences, sociability, calmness and accuracy were experienced as personal resources, and perfectionism, self-criticism, and fear of failure as personal demands.

Conclusion: Initiation to hospital-based practice requires from newly qualified midwives adaptation to new tasks: working with women in medium and high-risk care, managing tasks, as well as often receiving training in additional medical skills. Sociability helps newly qualified midwives in becoming a member of a multidisciplinary team; neuroticism and perfectionism hinders them in their work. Clear expectations and a settling-in period may help newly qualified midwives to adapt to practice. The initiation phase could be better supported by preparing student midwives for working in a hospital setting and helping manage expectations about the settling-in period.

INTRODUCTION

Newly qualified midwives' (NQMs) well-being after graduation is at stake, due to the demanding tasks and responsibilities NQMs face.[1] These new responsibilities may influence NQMs' professional confidence and competence, with possible negative consequences on the quality of the provided care,[2,3] or exit from the profession within the first year of graduation.[4] NQMs face different challenges when starting as a midwife in a hospital setting. Firstly, NQMs potentially lack confidence in their own clinical decision-making and they tend to struggle with the complexity of care.[5] Secondly, NQMs still need time to learn to prioritize their work and they usually need training in additional clinical skills, for example performing fetal blood sampling and coordinating treatment in case of emergencies.[6] Thirdly, NQMs need to become a trusted member of the multidisciplinary team in their work as hospital-based midwives.[7]

In different occupations, specific demands and specific resources lead to specific outcomes.[8] The Job-Demands Resource model (JD-R) model (figure 1) is often used as a theoretical model, due to the focus on different job demands and resources depending on the specific profession and a focus on positive and negative well-being.[8-10] *Job demands* (for instance work overload, heavy lifting or job insecurity) are aspects of the job requiring effort and are associated with mental or physical costs. *Job resources* (such as feedback, job control or social support) help the professional achieve job goals or reduce job demands.[11] In addition to job demands and job resources, the JD-R model integrates personal resources.[12] *Personal resources* are positive self-evaluations that are linked to resilience and refer to individuals' sense of their ability to control and affect their environments successfully,[13] and help employees in achieving goals.[8] Personal resources partially mediate the association between job resources and work engagement.[12]

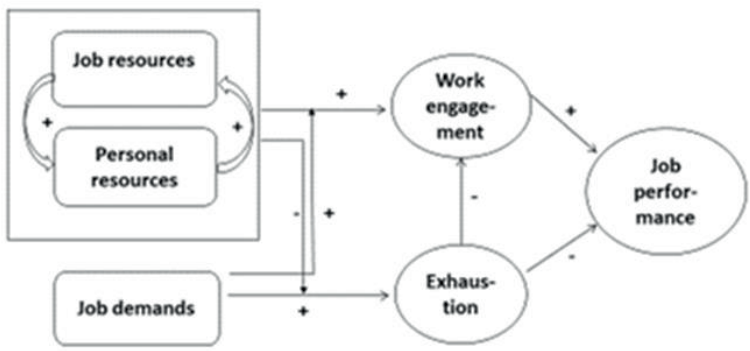

Figure 1. Adapted JD-R model of occupational wellbeing.[8]

Job demands of health care professionals that are related to negative outcomes are: a high workload, high emotional load, staff shortage, stressful situations with patients,[14] little support from management, few development opportunities, lack off professional recognition,[15] and long working hours.[16] Job demands on NQMs are different from the demands on more experienced colleagues: facing a reality shock in practice,[17] facing in practice a midwifery philosophy of care different from their own values,[18,19] and delay in securing employment and work allocations.[4] Job resources reported by health care professionals include the variety of the work and the patients,[14] and for midwives, supportive midwifery partners, work flexibility and autonomy as potentially protective for burn-out symptoms.[15] For NQMs, job resources differ from experienced colleagues: positive support and mentorship from colleagues,[4,20,21] working with clients in continuity of care,[22,23] and postgraduate training programs for mentors.[19,21]

In different occupations, hope and optimism,[24] extraversion, self-efficacy and conscientiousness,[9] are important personal resources. Neuroticism and perfectionism are personal demands, both for newly qualified and experienced midwives.[16,25,26] Neuroticism is characterized by a tendency to negatively interpret events and characteristics like self-consciousness and vulnerability.[27]

What is not known are the specific job demands and job resources are for In the Netherlands, a percentage of newly qualified midwives start work in maternity care as a hospital-based midwife. They are particularly prepared for working autonomously in the community. This context involves becoming a team member on a labor ward, without formal support programmes. Furthermore, research shows a gap of knowledge about personal resources and personal demands on NQMs which help or hinder them in their work as a hospital-based midwife.

The aim of this is study was therefore to identify job demands, job resources, personal demands and personal resources of Dutch NQMs working in a hospital setting during their first years in practice. The research question for this study was:

Which specific job- and personal demands and specific job- and personal resources are perceived by Dutch NQMs who start work as hospital-based midwives?

The outcomes of this study will help us to build specific support programmes to ensure NQMs' well-being in their first year in a hospital setting in the Netherlands. Next to identified job demands and job resources, specific knowledge about NQMs' personal demands and resources helping or hindering them, help us to prepare graduates for

working in a hospital setting. The outcomes of this study provide insight in the demands and resources on the JD-R model for newcomers in the midwifery profession. This will help midwifery practice and midwifery education better prepare and support students and newly qualified midwives for working in hospital settings.

Background

The midwives' professional education in the Netherlands consists of a four-year Bachelor of Science (BSc) program at a university of applied sciences. When graduated, NQMs can register themselves in the BIG-register of the Health Ministry, indicating license to practice. The educational program meets the national and international standards of professional competencies,[1,28] and is taught with approximately 55% of time spent on theoretical education, and 45% in placements in primary, secondary and tertiary care settings.[29]

In the Netherlands, about 72% of midwives work in primary care, 28 percent work as hospital-based midwives.[30] Twenty percent of Dutch midwives has graduated abroad and about half of them is working as a midwife in a hospital setting.[30] Amongst Dutch NQMs over the last 20 years, about 22 percent start work in a hospital setting within the first year after graduation.[30] Hospital-based midwives bridge the gap between primary-care midwives and obstetricians.[31] The role of the hospital midwife differs from that of primary-care midwives in that hospital-based midwives function semi-autonomously under supervision of an obstetrician within a hospital setting. In this setting they routinely care for women during birth who are at increased risk, such as women requiring pain relief, birth complicated by meconium staining of the amniotic fluid, or post-term pregnancy.[31] In contrast to the United Kingdom, Australia and New Zealand, the Netherlands has no formal support programmes designed to help NQMs in their transition to practice.[6,21,32] Dutch NQMs' support exclusively depends on informal support, whether they work as a midwife in a community or in a hospital setting.

METHOD

We used a qualitative descriptive design for this study to explore the working experiences of NQMs in their first year in a hospital setting. Data were collected through semi-structured interviews in order to identify specific job demands and resources as well as personal demands and resources.

NQMs who graduated less than three years ago and work as hospital-based midwives in the Netherlands, were recruited for individual interviews. We assumed that for a period of three years, participants could recall their experiences in their first year of working in

practice with a good degree of accuracy. We invited NQMs who graduated from all three Dutch academies. Recruitment of NQMs took place via Dutch Midwifery Academies (list of alumni), social media (Facebook and LinkedIn), and through snowball sampling. Participants received written information (via e-mail) regarding the purpose of the study, including a consent form.

Two researchers (IB, LK) conducted the individual interviews between January and July 2018. A topic guide (Appendix I) was used for the interviews, based on the dimensions of the JD-R model. Interviews were all individual, except for one double interview at the request of the participants. Interviews were audio recorded and transcribed. Participants were provided with the transcript of the interview upon request. In one transcript, we removed a segment, as requested by the participant, because of possible recognition by colleagues of a specific situation.

Ethical considerations

In the Netherlands, ethical approval by an ethical committee is not required regarding this type of research (www.ccmo.nl). All participants gave written informed consent before the start of the interview. To ensure confidentiality, personal data of the participants were separated from the transcripts and saved according to the data management rules of the University of Groningen.

Data analysis

Interviews were analyzed thematically, using MAXQDA 11, and were open coded by two researchers (IB, LK). They discussed the codes until they reached consensus. Open codes were inductively categorized by the same researchers and axial coded in themes, using the different elements of the JD-R model (Schaufeli & Taris, 2014). After ten interviews, we started with an interim analysis. We then added more in-depth questions about personal resources, in order to gain more detailed information from participants.

After twenty interviews, we did not acquire new codes, which indicated data saturation.

FINDINGS

In total, twenty-one Dutch NQMs participated with a mean age of 26 years (range 22-33), as shown in table 1. The duration of the interviews ranged between 36 and 65 minutes.

Table 1. Background characteristics of NQMs working as hospital-based midwife (N=21)

Characteristics		**N (%)**
Midwifery education	The Netherlands	11 (53)
	Amsterdam/Groningen	*8 (38)*
	Rotterdam	*1 (4)*
	Maastricht	*2 (8)*
	Belgium	10 (47)
Year of graduation	2015	6 (28.5)
	2016	6 (28.5)
	2017	9 (43)
Age	Mean	26
	Range	22-34
Employment contract (hours per week)	0-36 (flexible)	3 (14)
	16-32	8 (38)
	32 –36	9 (42)
	?	1 (5)
Hospital	General	19 (90)
	University	2 (10)

All participants worked (n=20) or recently worked (n=1) as a hospital-based midwife. Except for one, all NQMs had the Dutch nationality, 47% graduated in Belgium, and the remaining 53% in the Netherlands. Participants had a contract for between 0.4 to 1.0 full time equivalent (FTE). Three participants had a temporary employment contract with flexible working hours and worked between 24 and 36 hours per month. Most participants (n=19) worked in a general hospital, two were employed by a university hospital.

An overview of the results is shown in figure 2 and categorized as job demands, job resources, personal resources and personal demands.

Job demands

The most important job demands (see also figure 2), according to the participants, were: high workload, becoming a team member, learning additional midwifery skills and procedures, providing care for women in mid and high risk and, job insecurity.

High workload

NQMs faced a high workload when they work on a maternity ward. Coordinating several delivery rooms at the same time was new for NQMs. During internships they only had to support one delivery at the time, but as a hospital-based midwife they had to manage different births simultaneously.

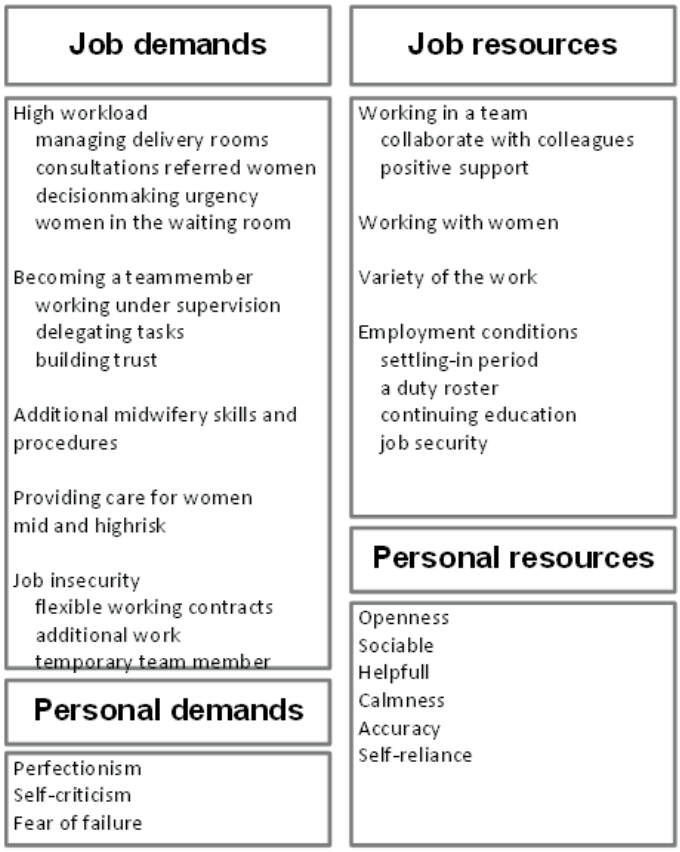

Figure 2. Perceived job resources, job demands, personal resources, personal demands by 21 Dutch NQMs, working in hospital-based midwifery care

Additionally, they also had consultations with women referred from primary care. The combination of coordinating several births and consultations caused a high workload. Therefore, they faced a high workload which required time management and fast decision-making in emergency situations.

'The difference [with primary midwifery care] is that you have a whole maternity ward, we have seven delivery rooms which we have to take care of and they are sometimes really full with five [patients] and when a referred patient comes in and then you have to do your consultation. You have to be really good in keeping an overview and setting your priorities! (P7)

NQMs mentioned that due to the high workload, they often could not give their women all the attention they wanted to provide. Women referred from primary care might have to wait too long before they had a consultation because of the hectic and unpredictable

nature of the maternity ward. Participants mentioned not feeling very well prepared for the hectic nature and high workload on the maternity ward.

Becoming a team member

Membership of a multidisciplinary team required competences in collaboration, cooperation, and leadership. For NQMs, especially in comparison to their internships, it took effort and adaptation to become a full member of the team. Furthermore, they also had to decide when direct supervision of the obstetrician was required.

'… it also depended on the colleagues you are working with. Is it someone who helps you and who guides you a little or is that someone who thinks: 'Well, another youngster, and let her prove herself'?' ***P4***

Participants had on one hand to learn how to delegate tasks to the obstetric nurses and on the other hand had to work under strict supervision of an obstetrician. Working under supervision of an obstetrician required collaboration and learning to function semi-autonomously. NQMs mentioned having to show their competence in order to build trust and reliability.

'There are a lot of dynamics in the hospital …. And it took me some time to realize which disciplines are involved and which agreements are made per hospital, and about protocols. And even if you have a protocol, the usual way of doing things can be different, and it takes a while before you know this. It differs per hospital, but also per obstetrician it is different again, and per nurse and per primary care midwife. That is so diverse, it really took me a while before I really knew how it works and I still run into issues now and then.' (P3).

Additional midwifery skills and procedures

Hospital-based NQMs faced different midwifery skills and procedures, which they were not specific trained for during their education. For instance, they had to learn how to insert Foley-catheters and fetal-scalp electrodes. These procedures required additional skills, which they had to learn in practice. Other midwifery procedures were trained before graduation, but NQMs were less experienced in practice, such as assessing fetal monitoring or suturing complex episiotomies. NQMs lacked routine in these complex procedures, so these procedures required effort.

'Especially with the CTG [cardiotocogram], you are immediately thrown in at the deep end. You have to work in practice with the CTG and it remains difficult and partially subjective. What one person thinks can be different from another and you must have a lot of experience with it if you want to be able to take advantage of it. And then you sometimes

make choices that you think would not have been necessary. So that in particular - and even more so at night when you are alone in the delivery room.' (P3)

Providing care for women

Working with women in mid- and high-risk care confronted NQMs with new challenges. Women with specific needs, specific socioeconomic- and cultural backgrounds or mental and psychiatric disabilities required effort and experience, which participants reported as lacking.

'… about the ethical things that I sometimes find difficult. We have a large refugee center nearby and we sometimes have difficulties with people from a different culture who want different things. Partners with different opinions about pregnancy and birth. Once I felt enormously threatened by a partner, because I did not work like the midwives act [in their country of origin]. And those are tricky things… We really learned it differently from how they want it. Yes, and then you do want to go a bit with the culture, but yes, you naturally also want to continue to do medically responsible things.' (P4)

Job insecurity

NQMs mentioned the type of employment during their first year in practice as challenging, such as flexible or temporary contracts. These types of employment were perceived by NQMs as insecure. NQMs sometimes felt like a conditional team member: they had to prove themselves as a hospital-based midwife in a short timeframe.

'I now increasingly have the end date in my mind… I'm still looking at other job vacancies. Yes, because they cannot give me clarity yet. That feels … quite annoying because I really feel like I am a part of this team … and then you are confronted with the fact that you do not have a permanent contract yet.' (P2)

Job resources

Important job resources, according to the participants were: working in a team; working with women; variety of the work; and employment conditions.

Working in a team

NQMs work as members of multidisciplinary teams with obstetric nurses, pediatricians and obstetricians. Teamwork provides NQMs with possibilities for collaboration and provides them with company during shifts and breaks. Shared tasks and responsibilities and the opportunity to delegate tasks to other team members were seen as important job resources.

'Teamwork is really important, that actually determines everything in your work, I think, because you need each other.' (P17).

Positive support from peers (other midwives), and accessible consultations with obstetricians, when available, were reported as helpful. One participant organized consultation meetings with experienced midwives for this reason. Another participant mentioned support and guidance from the manager of the ward as resource:

',.. my team manager was actually the one who was responsible for the focus on my settling-in period support. I had an evaluation interview with her on a weekly basis, just very briefly, to see where are you, how are you doing and how do we continue?' (P10)

Working with women

Rewarding feedback from women was perceived as a job resource. Doing the best for women and their families and building a relationship of trust with them was experienced as motivating.

'If it is just a beautiful birth: mother and child are doing well. Or, if people when they leave say: 'oh, thank you'. Or a follow-up check where people are just satisfied with you. That's the best thing. Or sometimes also a heavy situation that is nicely solved, a shoulder dystocia that you get out, that ends well.' (P14)

Variety of the work

The variety of the work in a hospital setting altogether appeared to be seen as a resource. NQMs felt satisfied and excited when they were able to deal with handling a lot of deliveries, and with different and unexpected, even complex, situations that challenged them.

'An acute situation that ends well, that was very thrilling ... I like the challenge when someone has a hemorrhage post-partum. I think okay, what can I do in order for her to be fine. Yes, I really like that kind of action.' (P13)

Employment conditions

An initial period for familiarization with the maternity ward, a period of lesser workload and the presence of supervising midwives were perceived as an important resource. When NQMs got the opportunity to take some weeks settling and were able to get supervision until they could manage different delivery rooms by themselves, they felt more secure and competent. Furthermore, clear expectations regarding what was expected from NQMs was an important resource. Stability in employment conditions

such as a secured contract, was also experienced as a resource. NQMs mentioned it was a job resource to be able to work with a set schedule, compared to the long on-duty hours in primary midwifery care during their internships. A roster provides NQMs with secured time off and thus time to relax and meet family and friends.

It gives me much more comfort in secondary midwifery care knowing that at the end of your shift, you hand over the phone and not take it to bed with you. (P3)

Possibilities for continuous education and resources for additional master or training programs were also perceived as resources.

Personal resources

Openness for new experiences, sociability, calmness and accuracy were experienced by our participants as personal resources which helped NQMs to perform well at the workplace (figure 2).

Openness for new and unknown situations helped them in their initial period in practice. Being extraverted and able to act socially helped NQMs' interaction with their team members and women and their families.

'I think it is very important to feel what someone needs or how they feel about themselves at such a moment. I usually try to find out how things went beforehand. For example if someone has contractions, just a chat about how it started. Or if they have children to ask about it. To break the ice. (P2)

Calmness helped participants in stressful situations so they were able to think clearly and keep an overview of what was happening to the different women. Working accurately and carefully were also mentioned as personal resources, both in the case of medical tasks as well as in administrative tasks. Being self-reliant as a person helped NQMs with autonomous decision-making and helped them dealing with feedback from colleagues and women.

'I also dared to make decisions and I dared to pick up [tasks] independently and it is really not that I needed help with anything and everything. I think that I can generally work independently.' (P13)

Personal demands

NQMs mentioned *personal demands*, hindering them while working in a hospital setting (figure 2). Participants named characteristics like perfectionism, self-criticism and fear of failure.

Perfectionism was seen at times as unduly demanding; some NQMs just wanted to do their job extremely well, which, for instance, made it difficult for them to stop thinking about their work when their shift was over. They were overthinking the decisions they made and doubting their actions. They also criticized themselves about their work, when they compared their work with more experienced colleagues.

'But also feelings of uncertainty, can I do it, am I doing it right? And sometimes sad feelings, I'll never get the hang of it. For example, if I had to start an induced labor, and then it didn't work as I expected… And then my colleague told me: we can easily break the membranes. And then I was so embarrassed. And well then, I started to break the membranes and then I didn't succeed. And then I let her do it. Then just disappointment, gloom, insecurity…' (P10)

Participants also identified a fear of failure which hindered them to perform in practice. NQMs reported at times sensing the feelings of clients or colleagues, but they did not dare to ask for feedback. Consequently, they took feelings of anxiety with them at home, and did not check whether these feelings were right or wrong.

'I am sometimes so much in doubt. Is it perfectionism, or is it some form of being afraid to fail. … I have noticed more than ever since my graduation that you carry responsibility for mother and child, that is a certain pressure that you feel. And then you think that can indeed be fatal… And perhaps it is a factor that I can be sensitive or afraid of doing things wrong.' (P2)

DISCUSSION

Within this study, we explored the specific demands and resources Dutch NQMs face in hospital settings. Newly qualified hospital-based midwives face new tasks and challenges they did not expect beforehand. The hospital context itself is also demanding, with a high workload, necessary team membership and job insecurity. On the other hand, the hospital also provides social support from colleagues, and the variety of women and tasks. Personal resources such as openness to new experiences, sociability, calmness and accuracy help newly qualified midwives in their initiation period. However, perfectionism, self-criticism and fear of failure were perceived as personal demands.

Similar job demands have been reported previously, with studies of NQMs reporting a high workload, working with women with complex needs and learning additional medical procedures.[17] In our study we identified job resources in hospital setting that are similar to findings in other studies on NQMs: working in a supportive team, working with women and the variety and diversity of the work.[21,23,33] However, this study added to the previous

evidence the demands put on Dutch NQMs by the process of becoming a trustworthy team member and working under insecure employment conditions. Additional personal demands are personality traits: perfectionism, self-criticism and fear of failure. We identified specific personal resources, such as being an extravert and having sociable traits, next to calmness and self-reliance in our study,

In line with the findings of Fenwick et al.,[23] we found that the importance of a supportive team with available colleagues is an important job resource for NQMs.[23] The importance of the support from team managers, helping NQMs or hindering (when lacking) to make their initial period in practice successful is similar to previous findings.[19] However, Dutch NQMs mentioned the need for experienced colleague midwives and supportive obstetricians as important to adapt to the complexity and hectic nature of a maternity ward. Dutch hospital-based NQMs lack opportunities to work together with experienced midwives as opposed to other countries, where NQMs are provided with mentors.[4,21,23] This highlights the absence of formal mentorship and support programmes for these starting professionals in the Netherlands. A lack of support from experienced midwives can also hinder the further development of professional identity and sustaining resilience, as shown by Hunter and Warren.[20] Adamson et al.[34] make similar observations on the importance of formal collegial support in their study on social workers' resilience.

In our study NQMs explicitly mentioned working together with others in the same shift as a job resource, which differed from other studies. This could be explained by the socialization of midwives: they are mostly prepared for working in primary care, where they work mostly alone in the community.[35]

Working with women was mentioned by our NQMs as a job resource, similar to previous research.[23,36] In contrast with other studies on NQMs, in our study the variety and unpredictability of the job was mentioned as rewarding. It provided Dutch hospital-based NQMs with excitement. A possible explanation for this finding could be the Dutch organization of maternity care, whereby most midwives work in primary care settings.[30] Hospital-based NQMs in our interviews compared their work in the hospital with community-based midwifery. Although NQMs have had placements in both contexts, during the interviews participants compared the variety of their work in the hospital with the work as a midwife in the community: caring for low risk women.

Personal resources such as openness and calmness helped hospital-based NQMs in their work, similar to findings by Butler et al. about being an effective communicator.[37] Job demands such as the high workload, becoming a team member, providing care for women with medium- and high risk, and insecure employment conditions have been

reported elsewhere previously.[3,6,22,38] In addition, we identified demands, such as learning additional medical skills and working under direct supervision from an obstetrician as demanding for Dutch NQMs. An explanation for this outcome could be the focus of the Dutch educational programmes for most midwives working in primary care. This could lead to unclear expectations for new graduates about future employments (for both working in the community and in the hospital setting). Job insecurity in our study is also considered a job demand with an impact on NQMs confidence.[4,26] Compared to other research, our findings on personal demands appear similar: neuroticism and perfectionism as poor personal resources.[9,13] However, on studies on NQMs, specific personal demands were not yet reported: our study identified perfectionism, self-criticism and fear of failure as specific demands among NQMs.

Strengths and Limitations

A strength of this study is that we used a theoretical framework. Working with the JD-R model, helped us identify job demands, job resources, personal resources, but also personal demands. Personal demands and resources were not explored in other studies on NQMs. Another strength in our study is that our participants reflected a representation of the Dutch hospital-based NQM population.[30] In our sample, for instance, we had participants educated in the different academies in the Netherlands as well as participants educated abroad.

In this study we explored and identified factors that influence well-being of hospital-based NQMs. A limitation of our study is that we did not explicitly relate these specific demands and resources to well-being and performance of hospital-based NQMs. Another limitation is that we only interviewed hospital-based NQMs working in the Netherlands. These outcomes are possibly not applicable in other countries, due to the differences in the educational programmes and organization of maternity care.

Implications for practice, education and research

Our findings suggest that NQMs in their settling-in period need support and guidance from their managers, colleagues and team. Experienced colleague midwives and obstetricians are essential for the adaptation of NQMs to a hospital setting. Team members must be aware of their importance as job resource: positive support helps NQMs become an effective team member. Colleague midwives are important as role models and, together with obstetricians, important for their expertise: providing NQMs with expert feedback and guidance.

Due to the lack or formal support for hospital-based NQMs in the Netherlands, team managers in hospital settings and the Dutch Royal Organization of Midwives may want to consider organizing settling-in and support programmes. For adaptation in the hospital setting, NQMs have to meet clear expectations about responsibilities and supervision in practice. Especially in hospital settings with a high workload and medium and high-risk care NQMs are vulnerable in their initiation period.

The initial education of midwives in the Netherlands could prepare midwives more explicitly for the different working contexts: in the community and in a hospital settings. Although 10-20 percent of new graduates applies for a job as hospital-based midwife,[30] it is important to raise awareness of the differences of working in primary and secondary/tertiary care and its implications for the settling-in period in practice.

Our findings indicate that Dutch NQMs found themselves not fully prepared for working in a hospital setting . Based on this finding, future investigation should focus on the ways in which midwifery students are prepared for working in different contexts and what helps or hinders them in their adaptation in hospital settings. Based on our findings, further quantitative research is necessary about NQMs wellbeing as well as working conditions associated with wellbeing. These outcomes can help with building specific support programmes for NQMs in practice.

CONCLUSION

For Dutch NQMs, working in a hospital setting the context itself is demanding, due to a high workload and the complexity of the work. NQMs face also new managing tasks and have to learn additional medical skills required for working as a hospital-based midwife. Personal resources such as sociability help NQMs in becoming a member of a multidisciplinary team. Neuroticism and perfectionism hinder NQMs in practice. Clear expectations and a settling-in period and support from colleague midwives and obstetricians help NQMs to adapt to work in a hospital setting.

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Appendix I Topic list Interviews

Job-demands Which challenges did you encounter in practice, just after graduation? Which tasks did you find challenging? Which tasks did you experience as easy? What did you have to learn, as you experienced working in a hospital setting? How did you experienced the job demands? In what way was the job demanding (physical and mentally)? How would you describe your feelings when working in a hospital setting? What are the main differences between working in a hospital setting as compared to work as a midwife in primary care?
Job-resources Which aspects of the job were facilitating in doing your work? Which factors provide energy / did you experience as motivating? At specific resources: what did it bring you? What helped this resource in your work?
Personal resources Which behaviour/qualities/skills helped in the execution of your work? Which factors helped you in your work as a hospital-based midwife? Which pitfalls did you see in yourself or your newly graduated colleagues? Do you think there are differences in personal qualities or skills between working in a hospital setting as compared to work as a midwife in primary care? How do you describe yourself on the following dimensions? - Are you more introvert or more outgoing/extravert? - Are you more inclined to go for your own interests or are you inclined to help others? - Are you careful or inclined to be a bit sloppy? - Are you emotionally stable or would you call yourself more unstable? - Are you open to different kinds of experiences / perspectives or do you find yourself more focused on a specific theme?
Are there other important subjects about your first experiences in hospital setting , not yet mentioned, but in your opinion important to mention?

CHAPTER 4

Midwives' occupational wellbeing and its determinants. A cross-sectional study among newly qualified and experienced Dutch midwives

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ABSTRACT

Objective: Internationally, about 40 percent of midwives report symptoms of burnout, with young and inexperienced midwives being most vulnerable. There is a lack of recent research on burnout among Dutch midwives.
The aim of this study was to examine the occupational wellbeing and its determinants of newly qualified and experienced midwives in the Netherlands. The majority of practising Dutch midwives are aged under 40, which could lead to premature turnover.

Design: A cross-sectional study was conducted using an online questionnaire that consisted of validated scales measuring job demands, job and personal resources, burnout symptoms and work engagement. The Job Demands-Resources model was used as a theoretical model.

Setting and participants: We recruited Dutch midwives who were actually working in midwifery practice. A total of N=896 midwives participated in this study, representing 28 percent of practising Dutch midwives.

Measurements and Findings: Data were analysed using regression analysis. Seven percent of Dutch midwives reported burnout symptoms and 19 percent scored high on exhaustion. Determinants of burnout were all measured job demands, except for experience level. Almost 40 percent of midwives showed high work engagement*;* newly qualified midwives had the highest odds of high work engagement. Master's or PhD-level qualifications and employment status were associated with high work engagement. All measured resources were associated with high work engagement.

Key conclusions: A relatively small percentage of Dutch midwives reported burnout symptoms, the work engagement of Dutch midwives was very high. However, a relatively large number reported symptoms of exhaustion, which is concerning because of the risk of increasing cynicism levels leading to burnout. In contrast to previous international research findings, being young and having less working experience was not related to burnout symptoms of Dutch newly qualified midwives.

INTRODUCTION

The organisation of care is changing, from a strict division between community and hospital care, there is a growing trend towards integrated care focusing on interprofessional collaboration. Women's preferences have also changed, with more women giving birth in hospital and expressing a greater need for pain relief.[1,2] These challenges may threaten the historically independent position of midwives in the Netherlands as guardians of physiological birth (at home)[1,2] and may also lead to unnecessary medical interventions in low-risk pregnant women.[3] In addition, on a global level, rising health care costs, increasing use of technology and interventions, and decreasing numbers of normal births are challenges for midwives.[2]

Midwives are at risk of burnout symptoms and occupational stress, which has implications for the quality of care for pregnant women.[4] Burnout is a process whereby professionals deplete their energy resources and their dedication, leading to reduced involvement with clients.[5] Work-related burnout among midwives internationally ranges between 20 and 60 percent.[4,6] Midwives are at risk for burnout when they feel unsupported, undervalued or not been able to work according to the midwifery philosophy.[7] Previous research on intentions to leave midwifery ranged from 21-43%.[8-10] Hunter et al. found that burnout, stress and anxiety levels were higher among midwives with ITL than among those without.[6] Important reasons for intentions to leave were dissatisfaction with the organisation of midwifery and/or my role as a midwife,[8] concerns about their mental and physical health, and the negative impact of an on-call schedule on personal life.[10]

Occupational wellbeing includes two constructs: burnout and work engagement.[11] High work engagement in healthcare professionals is associated with better mental and physical health, better workability and is beneficial for work performance and workplace safety.[12] Previous studies on midwives' wellbeing measured burnout, stress and anxiety and did not include work engagement.[4] It is known that healthcare professionals show high levels of work engagement due to job content: working with clients is meaningful and resourceful.[12] Including work engagement in studies on midwives can provide a comprehensive view on midwives' wellbeing.[11]

In the JD-R model (Fig. 1),[13] burnout and work engagement are interrelated constructs and can serve as distinct concepts covering the same underlying dimensions, namely work demands and work resources. For example, an individual's energy level can be a source of both vigour and exhaustion.[14]

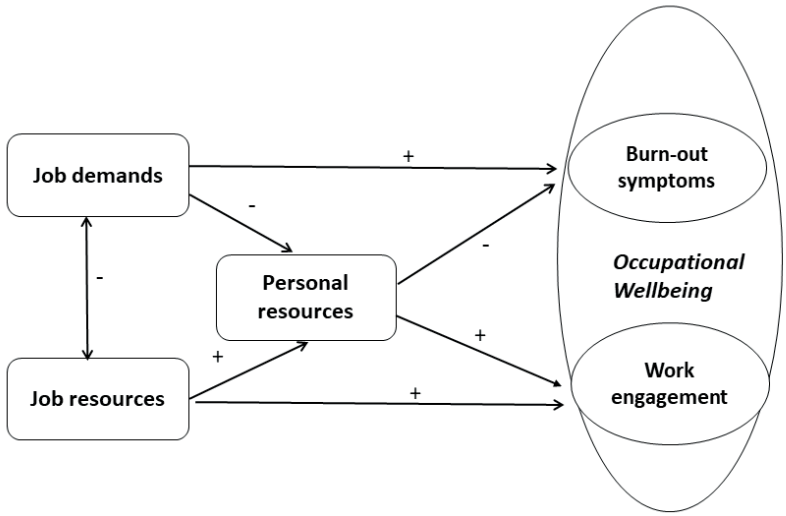

Figure 1. The Job Demands-Resources model (JD-R model)[15]

This heuristic model was developed to understand work-related wellbeing (both burnout and work engagement) by studying the influence of specific job characteristics (job demands, resources) and personal characteristics (personal resources) on wellbeing, and ultimately on performance outcomes.[5,13] The JD-R model is based on the assumption that job characteristics differ for various occupations.[16] Job demands are aspects of the job requiring effort and are associated with mental or physical costs.[13] Job resources help professionals to achieve job goals or to reduce job demands.[13] Personal resources are defined as the psychological characteristics or aspects of the self that are generally associated with resiliency and that refer to the ability to control and impact one's environment.[17] Personal resources contribute positively to wellbeing. They can also initiate an upward spiral of resources that reinforce each other, resulting in higher work engagement.[18]

Factors known to be associated with midwives' burnout symptoms are a low maturity level, young age, little work experience and being single.[4] Midwives are also at risk for burnout when they feel unsupported, undervalued or not been able to work according to the midwifery philosophy.[7] According to Wright et al., stress is related to increased exhaustion and may be higher among midwives in the community as compared to midwives in hospital settings.[19] Protective factors against burnout are: enjoying working with pregnant women, having supportive relationships with colleagues and working with like-minded midwives.[10] Preventing factors for burnout, are building resilience, positive coping strategies,[20] meditation, mindfulness, communication skills training and self-care efforts,[21] and a positive work environment and flexible working hours .[20]

In other occupational groups, autonomy and social support are associated with high work engagement.[5] In different occupations, personal resources such as self-esteem, self-efficacy, optimism and proactive behaviour are associated with high work engagement and relate negatively to burnout.[16,22,23]

The association of age and work experience with burnout symptoms highlights the need to study newly qualified midwives (NQMs) more intensively. Previous research on NQMs shows that the transition to practice causes stress and insecurity.[24] NQMs must adapt themselves to a new role with new responsibilities.[25] Furthermore, NQMs themselves felt competent but not confident in their first year in practice.[26,27] Our previous qualitative studies among Dutch NQMs have also identified differences in job demands and resources between community-based and hospital-based midwives.[28,29] Locum NQMs work long hours for different community practices, which they perceive as demanding.[28] Working with clients in the community, autonomous working and the variety of work were perceived as job resources.[29,30] Personal resources such as openness, flexibility and assertiveness helped them in their work, while perfectionism was perceived as hindering their work [28,29]

Due to the specific context of midwifery care in the Netherlands (see box), previously identified determinants of burnout symptoms among midwives elsewhere are not applicable in the Dutch working context. As far as we know, no recent research has been conducted into the occupational wellbeing of Dutch midwives.

There is a lack of knowledge about the levels of burnout symptoms and work engagement among Dutch midwives. We also do not know what job and personal demands and resources relate to midwives' occupational wellbeing,[28,29] nor whether work experience[4,24] or working context[24] are of any significance for midwives' occupational wellbeing.

The aim of this study is therefore to examine the occurrence of burnout symptoms and work engagement among Dutch midwives with different amounts of working experience and to assess the contributions of relevant job demands, job resources and personal resources to both burnout symptoms and work engagement.

Research questions:

1. What is the percentage of burnout symptoms and high work engagement among Dutch midwives and do these differ between newly qualified midwives and experienced midwives (EMs)?

2. What are the determinants of burnout symptoms and high work engagement in Dutch midwives and do these differ between newly qualified and experienced midwives?

With the outcomes of this study, we aim to contribute to the knowledge about the occupational wellbeing of midwives. Based on an understanding of the determinants of midwives' wellbeing, we make tailored recommendations for optimising that wellbeing, thereby contributing to the quality of midwifery care.

Midwifery care in the Netherlands

Dutch maternity care is strictly divided into primary and secondary midwifery care, whereby primary care midwives care for women with low-risk pregnancies and secondary care midwives take care of women with mid- and high-risk pregnancies under the supervision of an obstetrician. NQMs choose either employment at a hospital or self-employment in the community. Almost 75 percent of Dutch NQMs work in the community after graduation, with about 70% working as locum midwives.[31]

Primary care midwifery practices hire a locum midwife to cover for holiday, maternity or sick leave. Locum midwives are self-employed. To be recognised as self-employed ('autonomous professional without personnel') by the Dutch tax agency, locum midwives are required to work for different midwifery practices in one year in order to demonstrate their independence.

Nowadays, the way maternity care is organized tends to reduce the boundaries between primary and secondary care, which could adversely influence the level of work autonomy for primary care midwives.[47]

Registered Dutch midwives hold a BSc. degree from a university of applied science. This four-year programme allows them to register in the Ministry of Health's BIG register. The BIG register is a governmental body which entitles healthcare providers to practice in the Netherlands. PhD tracks have been developed at the midwifery academies in cooperation with associated universities. For a Master's degree, midwives are dependent on generic Master's programmes in research or health sciences.

PARTICIPANTS, ETHICS AND METHODS

In December 2018- March 2019, a cross-sectional study was conducted among newly qualified and experienced practising midwives in the Netherlands using a questionnaire with validated scales. Dependent variables were burnout symptoms and work

engagement. Independent variables were socio-demographic characteristics, job demands, job resources and personal resources.

Participants

As shown in figure 2, a random sample of practising midwives in the Netherlands was obtained from the Dutch midwives register of NIVEL (Netherlands Institute for Health Services Research), supplemented by all NQMs (< 3 years after graduation) in their database (N=1,301). A total of 60 letters were returned to sender, resulting in a NIVEL register sample of N=1,241. Six respondents refused to give informed consent and were excluded. The net response rate was 54.5 percent (n=676).

Announcements of this study in newsletters, on the website of the Royal Dutch Organisation of Midwives (KNOV) and in Facebook groups (midwifery academies, inspiration network of midwives) yielded another 461 respondents (Figure 2).

Questionnaires that were less than 100 percent completed were excluded from the analyses (n=241), producing a total of 896 eligible respondents. Our sample represents 28 percent of the total population of practicing Dutch midwives [31].

Ethics

Ethical approval for this study is not formally required in the Netherlands. The Medical Ethical Assessment Committee of the University Medical Centre of Groningen confirmed that the research does not fall within the scope of the Medical Research Involving Human Subjects Act (WMO) (reference number 2018/628).

Participant consent was obtained at the start of the questionnaire; participants could decide to stop filling in the questionnaire without explanation. Participant anonymity was assured as no name or other identifying data were collected.

Data collection

In December 2018, a letter was sent to the midwives in the NIVEL sample providing a brief introduction to the study, the aim of the study and a personal link to the questionnaire platform Qualtrics®. Reminders were sent four and eight weeks later.

After two months, additional recruitment started with a call-up in newsletters and private Facebook groups for Dutch midwives. Respondents could obtain a link for the questionnaire by responding to the call-up. They could not participate twice, due to a built-in check in Qualtrics. The online questionnaire could be completed on a smartphone, tablet or computer/laptop. Participants could contact the researcher with questions by email. They were able to pause during the questionnaire and continue later.

After every 50 completed questionnaires, a gift certificate (worth 50 euros) was awarded. Data collection closed at the end of April 2019.

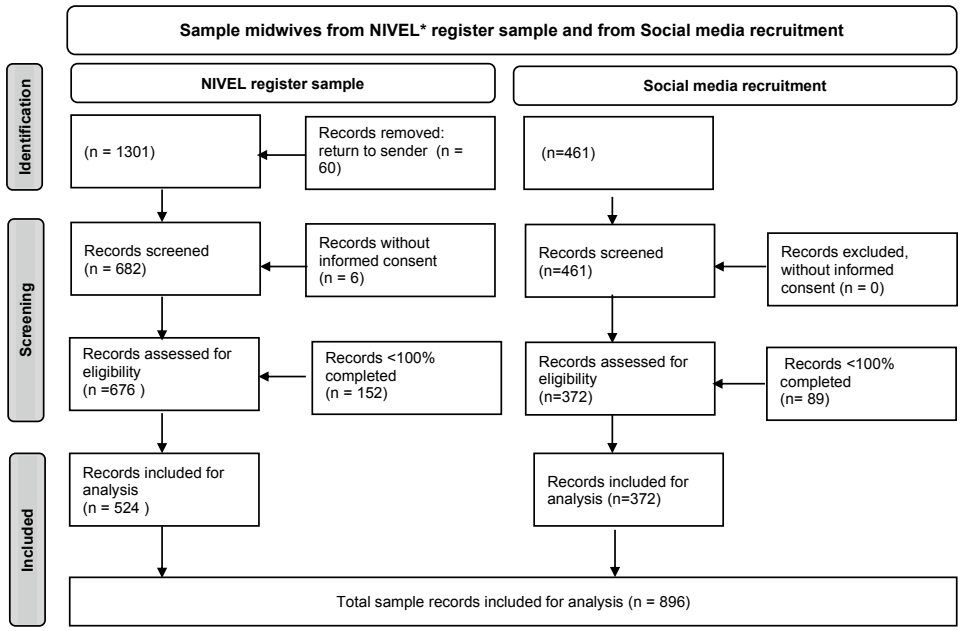

Figure 2. Flowchart study population Dutch midwives (N=896)

Measures

All measured variables are presented in figure 3.

To measure burnout symptoms, we used the Dutch version of the Maslach Burnout Inventory.[32] the UBOS-C (Utrecht Burnout Scale-clients) for professionals working with clients in social occupations or healthcare. Burnout is defined as a syndrome of exhaustion, cynicism and lack of professional efficacy.[13] We used the UBOS-C subscales on exhaustion and cynicism. Both subscales are consistent and stable over time, and correlations with other burnout-scales are high, which confirms their content validity.[32] The answers were given using a 7-point Likert scale (0=never; 6=always). The outcome was represented by mean scores that ranged from 0 to 6. The manual for the UBOS-C for healthcare professionals defines high exhaustion if scores are ≥ 2.5 and high cynicism if scores are ≥ 1.6.[32] We considered burnout symptoms as high when both exhaustion and cynicism scored high.[32]

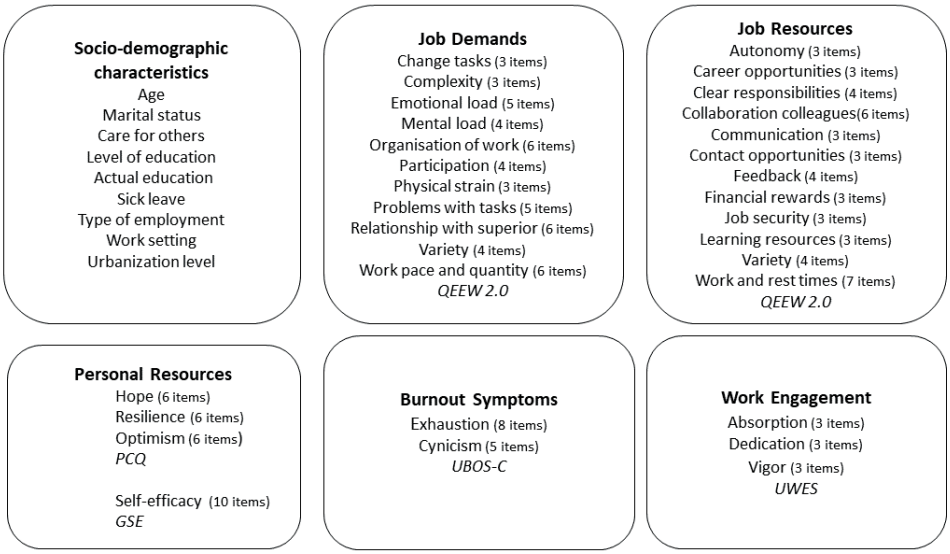

Figure 3. Socio-demographic characteristics, variables, scales and measurement instruments

To measure work engagement, we used the short version of the Dutch translation of the UWES (Utrecht Work Engagement Scale).[33] Work engagement is defined as a unique positive, fulfilling, work-related state of mind that is characterised by vigour, dedication and absorption[33] The UWES showed a high reliability and validity [33] The short version of the UWES consists of nine items. The answers were given using a 7-point Likert scale (0=never; 6=always). A total median score was calculated. Using the norm scores of the UWES, we considered a score of 4.67 or higher as high work engagement.[33]

Job demands and job resources were measured using the Dutch version of the QEEW 2.0 (Questionnaire on the Experience and Evaluation of Work).[34] The QEEW 2.0 has a high internal consistency.[35] Job demand variables included subscales as mentioned in Figure 3. Question items were scored on a 4-point Likert-scale (always, often, sometimes, never),[35] except for items in the subscales job security, financial rewards, learning resources and organisation of work, which were scored on a 5-point Likert scale (totally agree, agree, neutral, disagree, totally disagree). A score per subscale was obtained by adding the score of the items and dividing this by the maximum achievable–score and then multiplying it by 100. This resulted in continuous scores per subscale that ranged from 0 to 100. A higher score is the result of the most negative answer to each question on the scale. In the case of only the most positive answers, the scale score will result in 0.

Personal resources were measured using the Dutch translation of the Psychological Capital Questionnaire (PCQ).[36]. We used the constructs of psychological capital because they are relatively malleable and open to development.[37] For this study, optimism, hope and resilience were included in the questionnaire. The PCQ has a 6-point Likert scale (1=strongly disagree, 6=strongly agree). Each of the PCQ scale scores is calculated by taking the mean of all items in the scale. This resulted in a score that ranged from 1 to 6.[36] To measure self-efficacy, we used the Dutch General Self-Efficacy Scale (GSE).[38] The answers on the GSE consist of a four-point Likert scale (1=completely false, 4=completely true).[38] The score was obtained by calculating the sum of the scores of all 10 items (range from 10 to 40); a higher score means a higher degree of self-efficacy.[38]

Questions about socio-demographic characteristics were inspired by the WHELM studies.[39] We adopted questions about age distribution, marital status, educational level, working context and employment status and adapted them to the Dutch language and context.

Pilot testing of questionnaire

The preliminary online questionnaire was pilot tested online by a panel of 10 midwives, 5 fourth-year students and 5 midwives (lecturers). Based on their feedback, we added information about the time needed to complete the questionnaire to the introduction text. We also decided to exclude the relationship with superior and participation subscales because community-based midwives did not recognise these items in their work due do their self-employed status.

Analysis

The descriptive statistics relating to socio-demographic characteristics, work engagement and burnout symptoms are presented with reference to work experience. Missing data (missing items per subscale) were examined for all variables. Work engagement and burnout symptoms and the socio-demographic variables showed no missing data. For job demands, job resources and personal resources, the amount of missing data was less than one percent and completely random. We carried out a simple imputation of the missing data with the average score for each specific item.

We used descriptive statistics to answer the first research question about the occurrence of burnout symptoms and high work engagement, and the differences between experience levels. To identify the determinants of burnout symptoms and high work engagement, we first performed univariable regression analysis to assess associations between dichotomised dependent variables (burnout symptoms and work engagement). We then conducted a multivariable regression analysis between the dichotomised dependent variables (burnout and work engagement) and experience levels (NQMs and

EMs). We also corrected these associations for possible interacting variables such as workplace (community or hospital), marital status (single/with partner), autonomy, variety of work and support from colleagues. The selection of these interacting variables was derived from previous research.[4,5,28,29]

To answer the second research question about the determinants of burnout symptoms and work engagement, we used a univariable logistic regression analysis with dichotomised dependent variables (burnout symptoms and work engagement) in order to assess associations with the socio-demographic characteristics; job demands, job resources and personal resources.

The associations were presented as odds ratios (OR) with 95 percent confidence intervals (CI). A two-tailed p-value of .05 or less was considered statistically significant. Due to the limited number of NQM respondents, we were unable to perform a multiple logistic regression analysis of determinants of burnout symptoms and work engagement by experience level.

For the analyses, we used SPSS 25 (IBM SPSS Statistics for Windows, Version 25.0.).

RESULTS

Table 1 shows the socio-demographic characteristics of NQMs, EMs and the total sample. Our sample showed similar percentages to the population of Dutch midwives on the variables of age distribution, sex and country of initial education. Different proportions of our sample compared to Dutch midwives as a whole have been shown for the number of community midwives, self-employed and locum midwives.[31]

In the total sample, more than half of the respondents were aged under 40 (58%), 80 percent were living with a partner, 58 percent lived with children, and 81 percent worked in community practice. About 10 percent were also caregivers for a family member or close relative. Almost half of our respondents had a Master's degree (56%) and six percent were on sick leave (fulltime or part-time) at the time of completing the questionnaire.

Table 1. Frequencies (percentages) of **socio-demographic characteristics** of study population: split in Newly Qualified Midwives, Experienced Midwives, Total sample, Dutch midwives

Characteristic	NQM (n=182)	EM (n=714)	Total sample(N=896)	Dutch Midwives* (N=3221)
Age				
<30	*154(84.6)*	*73(10.2)*	*227(25.3)*	878(27.3)
30-39	*21(11.6)*	*279(39.1)*	*300(33.5)*	1175(36.5)
40-49	*7(3.8)*	*182(25.5)*	*189(21.1)*	645(20)
>50	-	*180(25.2)*	*180(20.1)*	523(16.2)
Sex				
Woman	*182(100)*	*706(98.9)*	*888(99.1)*	3157 (98)
Man	-	*8(1.1)*	*8(.9)*	64 (2)
Marital status				
Single	*32(17.5)*	*86(12)*	*118(13.2)*	
Partner	*114(62.6)*	*610(85.4)*	*724(80.8)*	
Other / non spec	*36(19.8)*	*18(2.6)*	*54(6)*	
Living with kids				
Yes	*26(14.3)*	*494(69.2)*	*520(58)*	
No	*156(85.7)*	*220(30.8)*	*376(42)*	
Caregiving others				
Yes	*2(1.1)*	*92(12.9)*	*94(10.5)*	
No	*180(98.9)*	*621(87.1)*	*802(89.5)*	
Country Initial education				
NL	*168(90.3)*	*581(81.4)*	*749(83.6)*	2538(79.7)
Belgium	*13(9.1)*	*112(15.7)*	*125(14)*	
Other	*1(.7)*	*21(2.9)*	*22(2.4)*	646(20.3)
Other qualifications				
None	*133(73.1)*	*251(35.2)*	*384(42.9)*	
Master Applied Science	*38(20.9)*	*409(57.3)*	*447(49.9)*	
Master of Science	*11(6)*	*48(6.7)*	*59(6.6)*	
PhD	-	*6(.8)*	*6(.7)*	
Actual education				
None	*137(75.3)*	*648(90.8)*	*785(87.6)*	
Master Applied Science	*37(20.3)*	*28(3.9)*	*65(7.3)*	
Master of Science	*7(3.8)*	*37(5.2)*	*44(4.9)*	
PhD	*1(.5)*	*1(.1)*	*2(.2)*	
Sick leave				
Yes	*2(1.1)*	*54(7.6)*	*56(6.3)*	
No	*180(98.9)*	*658(92.2)*	*838(93.5)*	
Not answered	-	*2(.3)*	*2(.2)*	
Working context				
Community practice	*168(92.3)*	*556(77.9)*	*724(80.8)*	2315(71.9)
Hospital	*9(4.9)*	*149(20.9)*	*158(17.6)*	906(28.1)
Combination of both	*5(2.7)*	*9(1.3)*	*14(1.6)*	
Urbanisation level				
Urban	*84(46.2)*	*278(38.9)*	*362(40.4)*	
Rural	*51(28)*	*149(20.9)*	*200(22.3)*	
Urban and rural	*47(25.8)*	*287(40.2)*	*334(37.3)*	
Employment status				
Employed	*19(10.4)*	*138(19.3)*	*157(17,5)*	1195(37,1)
Self-employed	*14(7.7)*	*496(69.5)*	*510(56.9)*	1465(45.5)
Locum	*149(81.9)*	*80(11.2)*	*229(25.6)*	561(17.4)

NQM= Newly Qualified midwives (<3years), EM=experienced midwives, * Dutch midwives according to the Dutch registrations.

Table 2 shows the frequencies and median scores on exhaustion, cynicism, burnout symptoms and work engagement. In total, 19 percent of midwives scored high on exhaustion and 10 percent scored high on cynicism, with about 7 percent of midwives having burnout symptoms.

Table 2. Frequencies (percentages) and Median (25th – 75th percentile) of Exhaustion, Cynicism, Burn-out symptoms and Work Engagement on, Newly Qualified Midwives (NQM), Experienced Midwives, and total midwives (EM)

Variables	**NQM (n=182)**		**EM(n=714)**		**Total: NQM+EM N=896)**	
	n(%)	Median (25^{th} ,75^{th})	*n(%)*	Median (25^{th}, 75^{th})	*n(%)*	Median (25^{th}, 75^{th})
Exhaustion		1.44(0.88, 2.00)		1.50(1.00, 2.00.)		1.50(1.00, 2.13)
Low	*153(84.1)*		*573(80.3)*		*726(81)*	
High	*29(15.9)*		*141(19.7)*		*170(19)*	
Cynicism		0.60(0.20, 1.00)		0.60(0.20, 1.00)		0.60(0.20, 1.00)
Low	*163(89.6)*		*641(89.8)*		*804(89.7)*	
High	*19(10.4)*		*73(10.2)*		*92(10.3)*	
Burnout symptoms						
Low	*166(91.2)*		*665(93.1)*		*831(92.7)*	
High	*16(8.8)*		*49(6.9)*		*65(7.3)*	
Work Engagement		4.67(4.00, 5.11)		4.33(3.56, 4.89)		4.33(3.56, 5.00)
Low	*94(51.6)*		*466(65.3)*		*560(62.5)*	
High	*88(48.8)*		*248(34.7)*		*336(37.5)*	

Exhaustion: a high score on exhaustion based on UBOS-C scores for healthcare professionals (scores ≥ 2.5) and Cynicism (scores ≥ 1.6) points, Burn-out symptoms (high scores on exhaustion **and** high scores on cynicism).[32] Work Engagement: a high score on Work Engagement based on the norm scores (UWES scores ≥ 4.67).[33]

The results of the associations between midwives' experience levels and both burnout symptoms and work engagement were shown in table 3. Experience level was not associated with burnout symptoms: NQMs did not have significantly higher odds of burnout symptoms than EMs (OR=1.31, 95% CI: 0.73-2.34).

Table 3 Associations between midwives' experience levels (NQM, EM) and Work Engagement / Burnout symptoms

Variables	**OR[a] (95% CI)**	**p-value**	**Corrected OR[b] (95% CI)**	**p-value**
Work Engagement	**1.76(1.27, 2.44)**	**<.001**	**2.09(1.31, 3.31)**	**<.001**
Burnout symptoms	1.31(0.73, 2.34)	0.38	1.31(0.68, 2.51)	0.42

OR=odds ratio, CI=confidence interval,[a] EM = reference group, [b] corrected for workplace, marital status, autonomy, variety, collaboration with colleagues.

NQMs demonstrated significantly higher odds (OR=1.76; 95% CI: 1.27-2.44) on high work engagement than EMs. Adjusted for possible interaction variables (workplace, marital status, autonomy, variety, collaboration with colleagues), the odds of high work engagement for NQMs increased (OR=2.09; 95% CI:1.31-3.31).

Determinants of burnout symptoms

Table 4a shows the results of the univariable logistic regression analyses assessing the determinants of burnout symptoms.

Table 4a. Associations of various characteristics with Burnout-symptoms based on experience years (NQMs < 3 years, EM >3 years: odds ratios (OR) and 95% confidence intervals (CI)

Burnout symptoms			
Variables	**NQM n=182** OR(95% CI)	**EM n=714** OR(95% CI)	**Midwives N=896** OR(95% CI)
BACKGROUND VARIABLES			
Age			
*<30**	1.00	1.00	1.00
30-39	1.56(0.73, 2.93)	1.06(0.66, 1.71)	1.24(0.76, 2.03)
>39	1.06(0.66, 1.71)	1.46(0.73, 2.93)	1.10(0.69, 1.75)
Marital status			
Single *	1.00	1.00	1.00
Partner	0.56(0.09, 3.58)	0.54(0.11, 3.00)	0.53(0.15, 1.80)
Living with kids	0.92(0.39, 2.23)	0.87(0.51, 1.48)	0.89(0.57, 1.39)
Care for others	0	1.21(0.60, 2.43)	1.24(0.62, 2.46)
Level of education			
BSc*	1.00	1.00	1.00
MSc applied	-	0.98(0.11, 8.58)	0.91(0.10, 7.91)
MSc	-	0.60(0.07, 5.28)	0.62(0.07, 5.38)
PhD	-	0.46(0.04, 4.90)	0.36(0.03, 3.91)
Sick leave	0	0.79(0.37, 1.70)	0.63(0.31, 1.27)
Type Employment			
Employed*	1.00	1.00	1.00
Self-employed	0.32(0.04, 2.53)	0.79(0.33, 1.87)	0.65(0.34, 1.25)
Locum	0	1.07(0.53, 2.19)	0.92(0.58,1.44)
Workplace			
Primary care*	1.00	1.00	**1.00**
Hospital	0	1.33(0.16, 10.74)	2.13(0.28, 16.47)
Combination	0	0.58(0.07, 5.07)	0.89(0.10, 7.41)
Urbanization			
Urban*	1.00	1.00	1.00
Rural	1.79(0.54, 5.91)	1.22(0.74, 2.01)	1.29(0.82, 2.03)
Combination	1.71(0.47, 6.27)	1.13(0.62, 2.06)	1.20(0.70, 2.05)
JOB DEMANDS			
Change tasks	**1.08(1.04, 1.12)**	**1.06(1.04, 1.08)**	**1.06(1.04, 1.07)**
Complexity	**1.12(1.07, 1.18)**	**1.05(1.03, 1.06)**	**1.0-6.6(1.04, 1.07)**

Emotional load	**1.09(1.05, 1.13)**	**1.07(1.05, 1.09)**	**1.08(1.06, 1.09)**
Mental load	1.00(0.97, 1.03)	**1.02(1.00, 1.04)**	**1.02(1.00, 1.03)**
Organisation of work	**1.08(1.04, 1.11)**	**1.06(1.04, 1.07)**	**1.06(1.05, 1.08)**
Physical strain	**1.03(1.01, 1.06)**	**1.02(1.00, 1.03)**	**1.02(1.01, 1.03)**
Problems with task	**1.14(1.09, 1.20)**	**1.08(1.06, 1.11)**	**1.09(1.07, 1.11)**
Variety	**1.05(1.02, 1.08)**	**1.02(1.00, 1.03)**	**1.02(1.01, 1.04)**
Work pace and quantity	**1.07(1.04, 1.11)**	**1.06(1.05, 1.08)**	**1.06(1.05, 1.08)**
PERSONAL RESOURCES			
Hope	**0.02(0.01,0.10)**	**0.24(0.17, 0.33)**	**0.19(0.14, 0.26)**
Optimism	**0.05(0.02, 0.17)**	**0.17(0.11, 0.27)**	**0.14(0.10, 0.22)**
Resilience	**0.07(0.03, 0.21)**	**0.26(0.18, 0.38)**	**0.21(0.15, 0.30)**
Self-efficacy	**0.70(0.59, 0.82)**	**0.87(0.82, 0.93)**	**0.84(0.80, 0.89)**

CI=confidence interval, OR=odds ratio, , **Significant: P<.05** , *= reference group

None of the socio-demographic characteristics were significantly associated with burnout symptoms. All measured job demands were positively associated with burnout symptoms, except for mental load in NQMs. All four personal resources (hope, optimism, resilience, self-efficacy) showed a negative association with burnout symptoms, with general self-efficacy showing the strongest association (OR=0.84, 95% CI:.80-.89).

Determinants of work engagement

Table 4b shows the results of the univariable logistic regression analyses assessing the determinants of work engagement. Socio-demographic determinants associated with work engagement are age, level of education, employment status and urbanisation level. Midwives aged between 30 and 39 showed significantly lower odds of high work engagement than those aged under 30. Midwives with Master's or PhD-level qualifications demonstrated higher odds of high work engagement than those with Bachelor's level qualifications. Midwives who were self-employed and working as locums demonstrated higher odds of high work engagement than midwives working at a hospital. For all midwives, working in a rural environment demonstrated higher odds of high work engagement than working in an urban area.

All measured job resources were associated with work engagement, with the exception of job security. Collaboration with colleagues and little influence on work and rest times demonstrated significantly lower odds of high work engagement. All four personal resources were also determinants of work engagement, with hope having the strongest positive association with work engagement in NQMs (OR=8.27, 95% CI 3.32-20.5).

Table 4b. Associations of various characteristics with Work Engagement, based on experience years (NQMs < 3 years, EM >3 years): odds ratios (OR) and 95% confidence intervals (CI)

Work Engagement			
(Sub)group	**NQM (n=182)** OR(95% CI)	**EM (n=714)** OR(95% CI)	**Midwives (N=896)** OR(95% CI)
Variables		**BACKGROUND VARIABLES**	
Age			
<30*	1.00	1.00	**1.00**
30-39	0	1.46(.73, 2.93)	**0.49(0.33, 0.73)**
>39	0	1.06(0.66, 1.71)	1.30(0,85, 1.99)
Marital status			
Single *	1.00	1.00	1.00
Partner	1.17(0.20, 6.94)	0.82(0.20, 3.31)	0.90(0.30, 2.70)
Living with kids	1.66(0.87, 3.14)	0.99(0.62, 1.57)	0.72 (0.51, 1.03)
Care for others	0.00	1.10(0.62, 1.96)	0.86(0.49, 1.51)
Level of education			
BSc*	1.00	**1.00**	1.00
MSc applied	1.54(0.43, 5.58)	**9.95(1.77, 56.11)**	**7.85(1.41, 43,62)**
MSc	0.88 (0.22, 3.52)	**10.78(1.93, 60.10)**	**9.32(1.68, 51.75)**
PhD	0	**14.00(2.09, 93.67)**	**9.80(1.57, 61.00)**
Sick leave	0	0.94(0.44,1.98)	0.75(0.36, 1.55)
Employment status			
Employed*	1.00	1.00	**1.00**
Self-employed	1.17(0.40, 3.46)	1.57(0.75, 3.25)	**1.97(1.16, 3.33)**
Locum	0.56(0.18, 1.71)	1.28(0.71, 2.33)	**1.73(1.19, 2.51)**
Workplace			
Primary care*	1.00	1.00	1.00
Hospital	1.62(0.26, 9.99)	2.73(0.67, 11.14)	2.42(0.80, 7.35)
Combination	0.83(0.09, 7.68)	2.26(0.53, 9.61)	2.28(0.71, 7.27)
Urbanisation			
Urban	**1.00**	**1.00**	**1.00**
Rural	**2.23(1.01, 4.96)**	**2.14(1.33, 3.44)**	**1.97(1.32, 2.94)**
Combination	0.81(0.36, 1.83)	1.17(0.71, 1.94)	0.93(0.62, 1.41)
JOB RESOURCES			
Autonomy	**1.05(1.02, 1.07)**	**1.03(1.02, 1.04)**	**1.04(1.02, 1.05)**
Career opportunities	**1.03(1.01, 1.05)**	**1.02(1.01, 1.03)**	**1.03(1.02, 1.04)**
Clear responsibilities	**1.05(1.02, 1.08)**	1.03(1.02, 1.04)	**1.03(1.02, 1.04)**
Collaboration colleagues	0.98(0.95, 1.00)	**0.98(0.96, 0.99)**	**0.97(0.96, 0.99)**
Communication	1.02(1.00, 1.03)	**1.01(1.00, 1.02)**	**1.01(1.00, 1.02)**
Contact opportunities	1.00(0.99, 1.02)	**1.02(1.01, 1.02)**	**1.01(1.01, 1.02)**
Feedback	**1.03(1.01, 1.04)**	**1.01(1.00, 1.02)**	**1.01(1.01, 1.02)**
Financial rewards	**1.02 (1.00, 1.03)**	1.01(1.00, 1.02)	**1.01(1.00, 1.02)**
Job security	1.01(0.99, 1.02)	1.01(1.00, 1.02)	1.00(1.00, 1.01)
Learning resources	**1.05(1.03, 1.08)**	**1.05(1.03, 1.06)**	**1.05(1.03, 1.06)**

Variety	**1.04(1.02, 1.07)**	**1.05(1.03, 1.06)**	**1.04(1.03, 1.06)**
Work and rest times	**0.97(0.94, 0.99)**	0.99(0.98, 1.00)	**0.99(0.97, 1.00)**
PERSONAL RESOURCES			
Hope	**8.27(3.34, 20.5)**	**4.03(2.73, 5.96)**	**4.46(3.14, 6.33)**
Optimism	**2.17(1.14, 4.14)**	**2.40(1.65, 3.50)**	**2.14(1.56, 2.93)**
Resilience	**4.84(2.46, 9.52)**	**2.24(1.61, 3.11)**	**2.45(1.84, 3.26)**
Self-efficacy	**1.13(1.04, 1.24)**	**1.19(1.12, 1.26)**	**1.16(1.10, 1.21)**

CI=confidence interval, OR=odds ratio, , **Significant: P<.05** , *= reference group

DISCUSSION

In this study, we assessed the occupational wellbeing of Dutch midwives as reflected in burnout symptoms and work engagement. Burnout symptoms were shown by seven percent of the respondents. The individual indicators showed even higher percentages among the respondents: 19 percent had high scores on exhaustion and 10 percent had high scores on cynicism. There were no differences in the frequency of burnout symptoms between NQMs and EMs. All measured job demands were significantly and positively associated with burnout symptoms.

Almost 40 percent of Dutch midwives reported high work engagement; NQMs showed the highest percentage (49%), compared with 35 percent for EMs. A lower level of experience was significantly associated with high work engagement. Determinants of high work engagement were age below 40, education at Master's and PhD level, self-employment and working in a rural environment. Job resources associated with high work engagement were career opportunities, the availability of learning resources and feedback, a high degree of autonomy and variety in work activities. All personal resources – hope, resilience, optimism and self-efficacy – were associated with high work engagement and lowering the odds of burnout symptoms.

The results for burnout symptoms among Dutch midwives differed from international outcomes. About seven percent of our respondents reported burnout symptoms: a combination of high exhaustion and high cynicism. Internationally, 20-60 percent of midwives display burnout symptoms.[4] There are three possible explanations for these differences. Firstly, the choice the UBOS-C versus that of the CBI (Copenhagen Burnout Inventory) in the WHELM studies.[4] The CBI measures three different subscales of burnout: work, personal and client burnout.[4] Among Swedish midwives, for example, 40 percent scored high in the personal burnout subscale, while work burnout and client burnout were around 15 percent.[40] Our study only measured work-related burnout symptoms. The differences In personal burnout symptoms might explain our relatively low burnout figures. Secondly, our sample may differ from the norm group for the UBOS-C. The norm

score group of the UBOS-C is based on 10 percent primary care professionals, while 81 percent of our sample were primary care midwives.[32] Working in the community with continuity of care protects against burnout symptoms.[4] The cut-off point for burnout symptoms might therefore be too strict for our sample.

The occurrence of exhaustion among Dutch midwives is a reason for concern, despite the low levels of burnout symptoms: about one in five Dutch midwives suffered from exhaustion. The burnout percentages are relatively low due to the low percentages of cynicism within this group. High scores on exhaustion combined with high scores on work engagement indicate that this group remains energetic because of their motivation for their work and the buffers against burnout symptoms.[5] However, there is a risk that cynicism will increase if scores on job resources decline. This could cause this group to become less committed to their work and less involved with their clients, resulting in lost working days due to sick leave, with a risk of them leaving the profession.[5]

The vulnerability of NQMs to burnout symptoms, based on previous research by Suleiman et al., could not be confirmed in our population.[4] A possible explanation might be the difference in the working context of Dutch midwives, whereby most NQMs work in a community setting,[31] which provides them with more job resources than hospital-based midwives.

This study is the first to measure work engagement using a large sample of midwives who are working in different contexts. Other international studies on midwives' wellbeing do not report work engagement,[4] or studied a small sample of hospital midwives,[41] making a comparison within the occupational group of midwives impossible. However, similar results regarding work engagement were found among Dutch doctors in postgraduate training (residents) (43% highly engaged doctors vs 38% highly engaged midwives)[42] This could be explained by the meaningful and resourceful work that healthcare provides.[12]

Our study shows the relevance of reporting work engagement in studies on midwives' wellbeing. Although burnout and work engagement are intertwined constructs, previous research on the determinants of midwives' occupational wellbeing has only identified associations between job demands and burnout symptoms, and not between job resources and work engagement.[4,17] Adding work engagement and job resources to research on midwives may provide a more comprehensive view on their wellbeing.

The determinants of high work engagement – higher educational levels and self-employment – are consistent with previous research.[12] In this study, however, a young age and little working experience were determinants of high work engagement, in contrast with the outcomes of Hakanen et al.[12] A possible explanation for these

differences could be that Dutch NQMs are able to begin practice with a competence level that is already high.[43] The novice level in other occupations might explain lower levels of work engagement.[12] Another explanation could be a lack of job or personal resources, according to the JD-R model;[13] in our findings, a lack of support from colleagues and an imbalance in work and rest times were associated with lower odds of high work engagement.

The results of our study reveal that personal resources – hope, resilience, optimism and self-efficacy – were positively associated with high work engagement and negatively associated with burnout symptoms. These findings are consistent with previous findings on wellbeing in other occupations.[44] Although personal characteristics were measured in studies on midwives' occupational wellbeing, personal resources are a relatively new addition to these studies.[13] The importance of conserving and optimising personal resources as part of midwives' wellbeing were supported by this study.

Our findings added specific knowledge about the importance of personal resources for NQMs. In our previous qualitative studies, Dutch NQMs mentioned openness, flexibility and setting boundaries as important personal resources in their work in midwifery practice [28,29] Dutch NQMs mentioned different personal demands as hampering their work. In line with these outcomes, our study suggests that all four personal resources are strong determinants of high work engagement.

Strengths & limitations

A first strength of this study is that, to our knowledge, this study is unique in that it explores both burnout symptoms and work engagement among midwives and uses the JD-R model as its theoretical framework. The JD-R model, which incorporates both positive and negative wellbeing, provides us with a comprehensive view of occupational wellbeing.[16] Midwives seem similar to other healthcare professionals: highly engaged in their work and therefore willing to deal with job demands because of their involvement with clients. If burnout symptoms alone are investigated, it is not possible to show a process of declining engagement. A second strength of this study is the use of validated scales in the questionnaire to increase reliability. A third strength is the generalisability to the population of community-based midwives. In this study, we had a larger number of community-based midwives (81%) than in the Dutch population of midwives as a whole (72%). Our study population included a quarter of the population of Dutch midwives who were currently practising, with comparable percentages on background variables, except for work setting. Our findings are less generalisable for hospital-based

midwives, however, because of the small number of hospital-based working midwives who responded.

This study also has some limitations. We do not know how the non-response influenced the levels of exhaustion and burnout symptoms. Employees with high scores on burnout symptoms seem less likely to fill in the questionnaire.[45] We may therefore have underestimated the prevalence of burnout symptoms. Another limitation is that we were unable to conduct a multiple regression analysis of work engagement and burnout symptoms with predicting variables for both NQMs and EMs. For a prediction model, 10-15 cases per variable are needed for midwives with high levels of the dependent variable.[46] We cannot therefore arrive at any conclusions concerning predictors of burnout and work engagement. Another limitation of this study is its cross-sectional design, which does not allow us to report causal relationships between different variables and midwives' wellbeing. In addition, this study was performed in 2019, which is also a limitation.

Recommendations for research and practice

International research is recommended on work engagement among midwives to enable comparisons with midwives in other countries. However, the levels of work engagement among Dutch midwives cannot be extrapolated to midwives in other countries, although we did identify experience level as a determinant of work engagement. Further research is recommended to explore explanations for these differences in levels of work engagement between NQMs and EMs.

In this study, we applied a heuristic model for occupational wellbeing (the JD-R model) in the midwifery profession. Further quantitative research with a higher number of respondents is necessary to identify determinants of work engagement and burnout symptoms for both NQMs and EMs. With a multivariable model, it is possible to identify independent determinants of occupational wellbeing, which could support the wellbeing of different groups of midwives. Furthermore, prospective longitudinal research involving multiple assessments is needed in order to gain an understanding of patterns of work engagement and burnout symptoms over the course of many years.

Using the JD-R model,[13] we were able to present a comprehensive view of midwives' occupational wellbeing. By using this model, we added figures on work engagement among midwives, and we provided midwives with determinants which contribute to wellbeing. Therefore we propose that, in addition to a focus on lowering job demands, interventions that focus on an increase of job resources, such as career opportunities, the availability of learning resources and feedback, a high degree of autonomy and

variety in work activities as well as interventions which focus on the development of PR (such as hope, optimism, resilience and self-efficacy) might contribute to an increased wellbeing of midwives.

Based on our findings, we recommend building awareness among professional organisations and the profession itself about the importance of job and personal resources for midwives' occupational wellbeing. For example, it is important for midwives to retain certain job resources, such as a degree of autonomy and variety in their work. The recognition of these resources for midwives' occupational wellbeing must be considered for future developments in the organisation of midwifery care. Also, professional organisations must be aware of the impact of demands such as working hours and rest times on midwife's mental wellbeing.

Training programmes with a focus on conserving and optimising job and personal resources for midwives could enhance midwives' occupational wellbeing, reducing levels of exhaustion and strengthening work engagement. Based on our findings, the need for the midwifery curriculum to prepare students for working in practice is also about building awareness of the job demands and resources that midwives will face after graduation. Furthermore, strengthening and optimising students' individual personal resources before graduation could contribute to the building of a sustainable workforce.

CONCLUSION

Based on the findings of this study, the occupational wellbeing of Dutch midwives seems to be better than that of midwives abroad: a smaller percentage of midwives showing burnout symptoms and a larger number having high work engagement. The percentage of midwives with burnout symptoms is relatively low due to the low scores on cynicism. However, the percentage of midwives with high scores on exhaustion is concerning. Dutch NQMs had the highest odds of high work engagement compared to experienced colleagues. Being a young midwife with less working experience did not harm their work engagement and did not lead to burnout symptoms This study added the important role of job and personal resources as determinants of high work engagement among midwives. Optimising job and personal resources for midwives could help to retain midwives in the profession, enhance their occupational wellbeing and improve the quality of the care that they provide.

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CHAPTER 5

Intentions to leave and actual turnover of community midwives in the Netherlands.

A mixed method study exploring the reasons why

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ABSTRACT

Background: In the Netherlands, the turnover of midwives of relatively young age is high. This is concerning since a lack of midwifery experience can negatively affect the quality of maternity care.

Aim: To study the rate and the reasons for intending to leave, and to explore the reasons for leaving midwifery jobs in the Netherlands.

Methods: We used a mixed-methods design including a quantitative survey (N=726) followed by qualitative interviews (N=17) with community midwives.

Findings: Almost one third of the respondents considered leaving the profession. The decision to actually leave the job was the result of a process in which midwives first tried to adapt to their working conditions, followed by feelings of frustration and finally feelings of decreased engagement with the work. The reasons for leaving midwifery practice are an accumulation of job demands, lack of social resources and family responsibilities.

Discussion: Compared to international figures, we found a lower rate of midwives who considered leaving the profession. This could be explained by the differences in the organisation of midwifery care and the relatively high job autonomy of midwives in the Netherlands. Nevertheless, changes must be made in terms of decreasing the demands of the job and creating more job resources.

Conclusion: Innovations in the organisational structure that focus on continuity of care for pregnant individuals, job satisfaction for midwives and building a sustainable workforce may result in an increase in the retention of midwives. These innovations would ensure that women and their babies receive the best care possible.

INTRODUCTION

In the Netherlands, the workforce of midwives consists of a relatively low number of experienced midwives, leading to an unbalanced workforce.[1] Sixty-one percent of Dutch midwives are under the age of 40, which differs from most other countries.[1] For instance, the median age (37 years of age) of the Dutch population of midwives differs from that in the United Kingdom (47 years of age). [2] In the United States, 58% of midwives are 40+ years old compared to 38% in the Netherlands. Seventy-two percent of midwives in the Netherlands work in the community, 28% in the hospital.[1] A good balance between experienced and less experienced midwives ensures a stable workforce and contributes to good practice.[3] Experienced midwives can share their accumulated expertise and knowledge to less experienced midwives.[4] Low ratios of experienced midwives to less experienced midwives could negatively affect the delivery of safe care.[3] In order to maintain a balanced workforce, and taking into account that almost 90% of pregnant women in the Netherlands start care in midwifery care, it is highly important to gain insights into the number of midwives who intend to leave the midwifery profession, the underlying reasons for this intention to leave and the reasons for the actual turnover of midwives.[5,6]

The intention to leave a profession refers to the probability of staying or leaving the profession. Although the intention to leave a job does not necessarily mean actual turnover, it is one of the most important indicators of leaving a profession.[7,8] Intention to leave is often triggered by negative reactions to organisational factors (e.g. organisational culture or interpersonal relations), work-related employment factors (e.g. workload or financial rewards), employee factors (e.g. demographic factors such as years of experience or the area of work) or external aspects of the job (e.g. family issues and the availability of other compatible jobs).[8] These negative reactions (or triggers) are often followed by negative psychological responses, such as frustration and withdrawal. Withdrawal has been found to manifest itself as absenteeism, avoidance behaviour and lowered performance.[7,8]

In relation to the number of midwives who have intentions of leaving the profession, it is known that 66.6% of UK (United Kingdom)-midwives, 42.8% of Australian midwives and 67.3% of Canadian midwives considered leaving the midwifery profession in the last 6 months before completing the questionnaire.[2,9,10] The most commonly cited reasons for Canadian midwives' intention to leave were the negative impact of an on-call schedule on personal life, followed by concerns about their mental and physical health.[10] Within the UK study, the most common reason for considering leaving the profession

were shortages of staff at work, not being satisfied with the quality of care that they can give and being dissatisfied with working conditions and workload.[2] In addition, within the group of UK midwives who considered leaving the midwifery profession, there were higher levels of burnout, depression, anxiety and stress in comparison to the midwives who did not consider it.[2]

Turnover is often defined as the voluntary termination of membership to an organisation by an employee of that organisation.[2] Common reasons for leaving are dissatisfaction due to a lack of time to deliver appropriate care, shortage of staff and a high workload.[9] Moreover, studies show that midwives feel demoralised, disempowered, and overwhelmed by the medicalisation of birth, as well as a lack of autonomy.[2,11,12]

Despite this research on intentions to leave and the reasons for turnover, little is known regarding the reasons of community midwives in the Netherlands to leave the workforce. This study adds specific new knowledge and insights based on a maternity care system in which midwives work as autonomous medical professionals. This study focuses on elements such as the strong relation between the intention to leave and actual turnover and on the possibility that a midwife's performance could already be different once they intend to leave.

The aim of this study is to identify the rate and reasons of intention to leave and to explore the actual reasons for leaving the midwifery profession in the Netherlands. The following research questions will be answered:

1. What is the rate of intention to leave among community midwives?

2. What are the reasons for intending to leave among community midwives and do these reasons differ between newly qualified midwives and experienced midwives?

3. Why do community midwives really leave the profession?

PARTICIPANTS, ETHICS AND METHODS

To answer our research question, we used a mixed method sequential explanatory design: quantitative data was enriched with in-depth information to gain broad knowledge. The study consists of two parts:

1. A quantitative survey study of a sample of practising community midwives in the Netherlands to identify the rate and reason for the intention to leave.

2. A qualitative study consisting of in-depth interviews with community midwives who left the midwifery profession.

We used the results of part 1 to provide input for part 2.

Theoretical framework

We used the adjusted Job Demands and Resources model created by Hoonakker et al..[13] (Figure 1) as theoretical framework. The decision to use the JD-R model as a theoretical framework is mainly related to its heuristic nature, as it has the potential to identify the demands and resources for a specific professional group, in this case midwives.[14] Within this model, the wellbeing of a professional is dependent on two concepts: job demands and job resources. Job demands are the physical, psychological, social, and organisational characteristics of a job. Job resources are the resources that help to achieve work goals or reduce the demands of the job, including receiving feedback, having task control, or having social support. Wellbeing itself is a combination of work engagement and exhaustion/burnout.[13-15] Exhaustion/burnout can ultimately lead to withdrawal behaviour, intending to leave and, ultimately, to actual turnover, which is the focus of this study.[13]

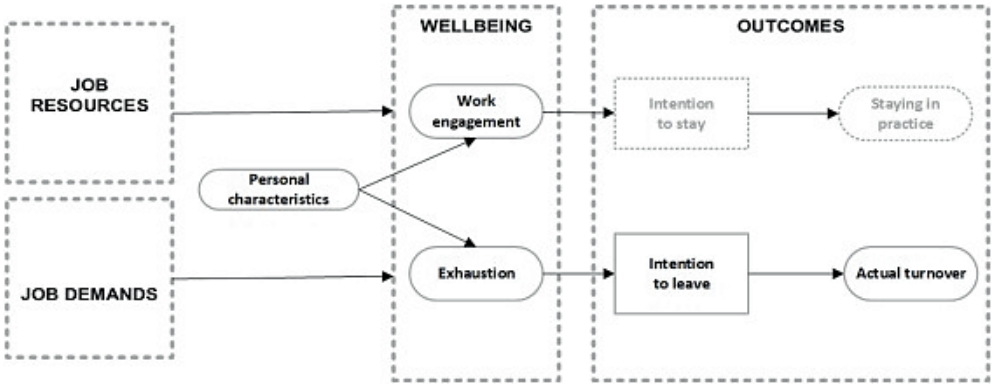

Figure 1. The adjusted Job Demands and Resources model, including the possible outcomes of stress/burnout and job satisfaction/commitment[13]

PART 1 Survey study

In part 1, we conducted a cross-sectional study. We used three questions that were part of the 'Dutch national wellbeing of midwives study',[16] measuring the wellbeing of midwives in the Netherlands. The 'Dutch national wellbeing of midwives study' was conducted in 2019. This cross-sectional study was carried out among practising midwives in the Netherlands using a questionnaire that was constructed using validated scales.[16] The validated scales used were the Dutch versions of: (1) the Maslach Burnout Inventory, the UBOS-C (Utrecht Burnout Scale-clients) for professionals working with clients in social professions or health care,[17] the UWES (Utrecht Work Engagement Scale),[18] the

QEEW 2.0 (Questionnaire on the Experience and Evaluation of Work),[19] the Psychological Capital Questionnaire (PCQ),[20] and the General Self-Efficacy Scale (GSE).[21] Dependent variables in this study were burnout symptoms and work engagement. Independent variables were sociodemographic characteristics, task demands, resources at work, and personal resources.

Study population

Midwives in the Netherlands who work in community care were included. In textbox 1 we have provided background information regarding the way community midwives work in the Netherlands. Midwives working only in an hospital, or education or research were excluded.

Background information regarding the way community midwives work in the Netherlands.

The professional education of midwives in the Netherlands consists of a four-year direct entry Bachelor of Science programme and gives access to registration in the so-called BIG-register of individual health care professionals of the Health Ministry, allowing license to practice.[22]
According to the regulations of the Ministry of Education, the educational program entails 240 European Credits Transfer System (ECTS) on which 100 ECTS spend on placements (60 ECTS in community care settings). One ECTS stands for 25-30 hours workload. [23]
According to the national figures, 72% of the midwives work in a community-based setting, and 28% of the midwives work in a hospital-based setting.[1] A large proportion of midwives in the community work in independent practices, either as owners or as locums. Only a minority (4%) are employed at an independent practice.[1] Each midwifery practice offers 24/7 care. The default independent practice is set at 105 full care units. This means that a midwife takes care of the prenatal, natal and postnatal care of approximately 107 women annually.[24] Community midwives are self-employed, which means they can decide how many clients to take on and how much time to spend with each client. This also means that the number of working hours is not restricted, as is the number of days off. Practice assistants can help the midwife with administrative and organizational tasks.
Community midwives take care of women experiencing normal pregnancies and births and in postpartum periods. Women are referred to a hospital if risks of adverse foetal or maternal outcomes are high or if complications arise during pregnancy or childbirth. In the hospital, obstetricians, nurses and hospital midwives take over care.[25]

Every midwife in the Netherlands needs to renew her BIG-registration every five years.[22] The most important requirement for on-going registration is a minimum number of hours spent working as a midwife. Next to the BIG-register, 80% of midwives are registered in the quality register from the Royal Dutch Organisation of Midwives. A registered midwife has to show in a minimum of 200 hours continuous education, training.[25]
Currently, there is a move towards closer collaboration between the different professional groups in 'integrated care maternity care'. The finance system may change from separate payments for community and hospital-based maternity care to bundled payments for maternity care collaborations in which community midwifery care practices, maternity care organizations, ultrasound centres and hospitals participate. They will then be funded through the collaborative in which they work. This is a potential threat to the self-employed status of community midwives.

Recruitment

Recruitment of respondents took place between December 2018 and March 2019. The recruitment process consisted of two steps: in step one, a random sample of practising midwives (1,301 of the total population of 3,221 midwives in the Netherlands) registered in the database of the Netherlands Institute for Health Services Research (NIVEL) was used. This sample was supplemented with all Newly Qualified Midwives (< 3 years after graduation) that were available in the database. Midwives in the database had given permission to receive invitations to participate in research. A total of 60 letters were returned to sender, resulting in a NIVEL sample of N=1,241. Participant consent was obtained at the start of the questionnaire; participants could decide to stop filling in the questionnaire without explanation. Participant anonymity was assured as no name or other identifying data were collected.

In step two, the Royal Dutch Organisation of Midwives – in which 84% of midwives are a member – sent an email with information about the survey to all members. A link and QR code leading to the survey was attached. The first question was about giving informed consent.

Survey

The questions used from the survey of the 'Dutch national wellbeing of midwives study' are presented in Figure 2. Furthermore, demographic characteristics and workplace characteristics were collected. The intention to leave was measured using three questions (1. Have you considered leaving the profession of midwifery in the past six months?

[Yes/No], 2. What are the reasons you are considering leaving the profession? [nine predefined answers], and 3. Describe in your own words why you consider leaving the profession [see Fig. 2]).

Demographic characteristics

Age (<29, 30-39 40-49, 50-59, >60)

Marital status (Married/ cohabiting with children, Alone/ seperated, Living with own parents)

Children (yes/no)

Region (North, East, West, South) Workplace characteristics

Workplace characteristics:

Workplace (Community care, Hospital care, combination of community and hospital care)

Type of employment (Employed, Owner of a midwifery care practice, Locum)

Level of experience (Newly qualified 0 -3 years, Competent 3 -10 years, Experienced ≥10 years)

Level of education (Bachelor, Master of applied sciences, Master (university level, PhD)

Type of practice (Urban, Rural, Combination of urban and rural)

Intentions to leave questions:

Over de last six month have you considered leaving the midwifery profession? (yes/no)

Reasons: planned change in career, Family commitments, Health, Dissatisfaction with own organization, Dissatisfaction with organization of maternity care, Dissatisfaction with my role as midwife, Dissatisfaction with my pay, planned location move, Planned retirement, Other

What reasons have contributed to you considering leaving the midwifery profession?

Figure 2. Included questions regarding Dutch midwives' wellbeing, a national study[16]

Analysis

Descriptions of background and workplace variables were calculated and summarised. Next, we performed a descriptive analysis regarding the intention to leave using SPSS version 25.0. Also, we performed chi-square tests to compare the intentions and reasons to potentially leave between Newly Qualified Midwives and Experienced Midwives. The level of significance was set at $p<0.05$. Thereafter, we analysed the open-ended question in the survey. We read and reread the comments of respondents and initially coded the fragments independently from each other, then created categories. Next, we organised the categories into themes. [26] These themes were then ordered using the applied Job Demand and Resources model. [27] ATLAS.ti version 8.4 supported the qualitative analysis.

PART 2 Interview study

In part two, we performed 20 in-depth interviews with midwives across the Netherlands. We had to exclude three interviews from these 20 interviews because these midwives worked exclusively in hospital-based care. The included interviews lasted 45 minutes on average, three were conducted on-site, and 14 online.

Participants were recruited through Facebook pages for midwives, through the website of the Royal Dutch Organisation of Midwives, through snowball sampling, and through the researchers' networks. Potential participants were able to send an email to receive additional information about the study. They were invited for an interview after they agreed to participate. Eligible participants were community midwives who had stopped working in the midwifery profession within the past five years. We assumed that they would remember clearly what it was like to quit their jobs.

Data collection took place in March 2021 and April 2021. Prior to the interviews, a topic list was developed by two researchers. The topics were derived from the document analysis of the open-ended survey questions, a literature study, and the JD-R model. This topic list was tested twice on midwives who were not included in the target population. As a result, the order of topics was adjusted. The interviews were conducted by two researchers, respectively a researcher and a master student/midwife. All interviews were discussed by the entire research team, which allowed us to reflect on the possible influence that the researchers had on the interview process. Depending on the participant's preference, the interview could take place online or on-site. Online interviews were held via digital platforms (Microsoft Teams or Zoom). After 15 interviews, we did not derive new information. However, we decided to carry on with the five interviews which were already planned. All interviews were recorded (by audio and video) and notes were taken. After approximately three interviews, the findings were discussed among the researchers and the topic list was then adjusted slightly. After each interview, a summary was written. All interviews were conducted in Dutch and transcribed verbatim. The transcripts and summaries were member-checked by each participant. No adjustments were needed.

Analysis

We analysed the transcripts of the interviews by moving from inductive coding to a framework analysis. This included the following steps: 1. We developed a coding scheme; 2. The open codes were placed into categories by two researchers; 3. The applied JDR model by Schaufeli et al.[27] was used to order the developed categories. We then conducted a second analysis using a narrative analysis. In each transcript, we looked for the turning points that led to the decision to leave work as a practicing midwife. These turning points were collected in a separate document per participant so that we could properly examine whether there was a potential accumulation of reasons for the participant.[26] MaXQDA, version 2020.4 was used to analyse this data.

RESULTS

In the results, we show the background characteristics of the respondents (survey study) and the participants (interview study). In Table 2, the quantitative findings from the survey related to the rate of midwives with intentions to leave and which reasons they had for consideration to leave are shown. Next, the qualitative findings from the analyses of the open-ended questions of the survey and of the interviews with community midwives are described and presented in figure 3. Finally, the outcomes of the narrative analyses are shown.

Background characteristics of survey respondents and interview participants

In part 1, a total of 1,078 surveys were completed. We had to exclude 183 surveys because they had multiple missing variables.[16] We also excluded 169 hospital-based midwives. Our final sample consisted of 726 respondents. In part two, we performed 20 in-depth interviews with midwives across the Netherlands. We had to exclude three interviews because the midwives had worked exclusively in hospital-based care. In Table 1, the background characteristics for both the respondents (in part 1) and the participants (in part 2) are presented. In the text below, the word 'respondent' refers to midwives who completed the survey, the word 'participant' refers to the midwives who were interviewed.

Most midwives (61.2%) who responded to the survey were younger than 40 years of age, were parents/guardians with their children living at home (56.9%), were married, or lived together with their partner (83.7%) (Table 1). Of the interview participants, 35.5% were younger than 40 years of age. Most of them were parents/guardians (76.5%) and were living with a partner (82.4%). Regarding workplace characteristics, most midwives worked as community midwives (respondents: 98.1%; participants 82.4%), were owners of a midwifery care practice (respondents: 64.2%; participants: 41.2%), had more than 10 years of experience in midwifery care (respondents: 53.9%; participants: 64.7%) and had an urban-based practice (respondents: 42.6%; participants: 35.3%). Compared to the population of midwives in the Netherlands, our sample respondents had a similar age distribution and similar figures in employment status (self-employed and locum midwives).[1]

Table 1. Descriptives of background characteristics and workplace characteristics of survey respondents (N=896) and interview participants (N=20)

Background characteristics Ref. = Reference category	**Survey Respondents N=726 (%)**	**Interview Participants N=17 (%)**	**Community midwives in NL N=2429 (%)***
Age			
≤ 29	203 (28.0)	1 (5.9)	694 (28.6)
30-39 (ref.)	241 (33.2)	5 (29.4)	833 (34.3)
40-49	146 (20.1)	2 (11.8)	476 (19.9)
50-59	101 (13.9)	5 (29.4)	313 (12.9)
≥ 60	35 (4.8)	4 (23.5)	114 (4.7)
Marital status			
Married/cohabiting with children (ref.)	608 (83.7)	14 (82.4)	
Alone/separated	71 (9.8)	3 (17.6)	
Living with own parents	47 (6.5)	-	
Children			
No (ref.)	313 (43.1)	3 (17.6)	
Yes	413 (56.9)	13 (76.5)	
Missing	-	1 (5.9)	
Workplace characteristics			
Workplace			
Community care (ref.)	712 (98.1)	14 (82.4)	2429
Combination of community and hospital	14 (1.9)	3 (17.6)	Unknown
Type of employment			
Employed (ref.)	65 (9.0)	5 (29.4)	278 (12.6)
Owner of a midwifery care practice	466 (64.2)	7 (41.2)	1444 (62.6)
Locum	295 (26.9)	5 (29.4)	583 (25.3)
Years of experience			
3-10 years (ref.)	167 (23.0)	5 (29.4)	
0-3 years	168 (23.1)	1 (5.9)	
> 10 years	391 (53.9)	11 (64.7)	
Type of practice			
Urban (ref.)	309 (42.6)	6 (35.3)	
Rural	187 (25.8)	4 (23.5)	
Combination of urban and rural	230 (31.7)	7 (41.2)	

*Kenens et al. (2020)

Rate of intention to leave (survey study)

One third (33.7%) of the respondents did consider leaving the profession (see Table 2), with no significant differences between newly qualified midwives and experienced midwives. The main reasons mentioned were: 'dissatisfaction with organisation of midwifery care', 'family-commitments' and 'health'. We found significant differences between newly qualified midwives and experienced midwives regarding reasons for

potentially leaving. Experienced midwives were significantly more likely to report that they were potentially planning to leave because they were dissatisfied with the organisation of maternity care. In addition, they significantly more often reported family commitments related to reasons for consideration to leave as compared to Newly Qualified Midwives.

Table 2. Intention to leave the profession, reasons for consideration to leave (N=726), and the combination of reasons to leave. Split into the total group community midwives**,** experienced midwives (EM) and newly qualified midwives (NQM*)*

Intention to leave midwifery practice	**Total N(%) 726 (100)**	**EM n(%) 558 (76.9)**	**NQM n(%) 168 (23.1)**	**X^2 (p)***
Yes	245(33.7)	194(34.7)	51(30.4)	1.12(.29)
Reasons for consideration to leave (n=245)				
Dissatisfaction with organisation of maternity care	103(14.2)	92(16.5)	11(6.5)	**10.48(.00)**
Family commitments	88(12.0)	77(13.7)	11(6.5)	**6.63(.01)**
Health	62(8.4)	54 (9.7)	8(4.8)	3.99(.05)
Dissatisfaction with own organisation	55(7.6)	48 (8.6)	7(4.2)	3.63(.06)
Dissatisfaction with my role as a midwife	44(6.1)	35 (6.3)	9(5.4)	.19(.06)
Dissatisfaction with my pay	33(4.5)	24 (4.3)	9(5.4)	.33(.57)
Planned change in career	23(3.2)	18(3.2)	5(3.0)	.03(.87)
Planned retirement	11(1.5)	11(2.0)	0(0)	1.10(.30)
Planned location move	9(1.2)	5(0.9)	4(2.4)	.33(.13)
Other	95(13.1)	64(11.5)	31(18.5)	**5.54(.02)**
Combinations of reasons to leave (n=245)				
Family commitments + Dissatisfaction with organisation of maternity care				44
Health + Dissatisfaction with organisation of maternity care				25
Dissatisfaction with organization of maternity care + Dissatisfaction with own organization				24
Dissatisfaction with own organisation + Family commitments				21
Family commitments + Health + Dissatisfaction with organisation of maternity care				15

EM=Experienced midwives (>3 years working experience), NQM is Newly Qualified Midwives (<3 years of working experience) * EM compared to NQM

Reasons for consideration of leaving the profession (open-ended questions survey)

In response to the open question, 91 respondents left a comment. These comments varied in length, from single-word comments to comments containing a few sentences.

The code tree of this part of the study is presented in Figure 3. This figure also shows the results of the in-depth interviews. Several qualitative demands (work-home conflict, being on-call 24/7 and traumatic events) and one quantitative demand (work overload) were mentioned. The amount of administrative and organisational tasks was also mentioned as an important reason for the intention to leave the job. Respondents described a lack of job resources as reason for their intention to leave the profession. Several social resources were perceived as deficient, such as the involvement of partners, collaboration problems, support from colleagues and not feeling recognised as a professional midwife. Discrepancies between their professional values and actual practice were attributed to as a lack of organisational resources, as well as dissatisfaction with pay and employment status. Lack of developmental resources consisted of both the perceived lack of career opportunities and a lack of learning resources. The category of responsibilities was added to the original code structure. The respondents described the responsibilities they face in their job as demanding.

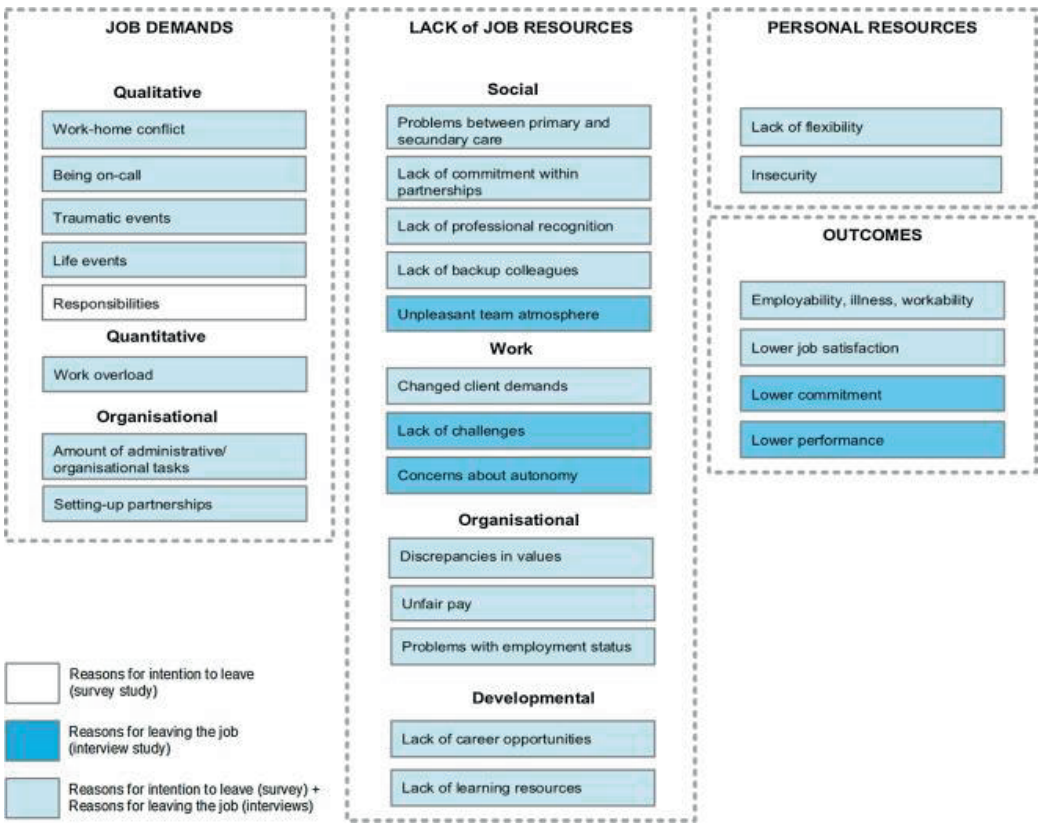

Figure 3. Code tree including themes and categories of the intention to leave and reasons to leave; analysis of the open-ended survey question (N=91), and the in-depth interviews (N=17), thickness of the lines is related to the number of codes assigned

Reasons for leaving (interview study)

Figure 3 shows the code tree of the themes and categories related to the reasons for leaving the profession. This figure shows that the reasons for the intention to leave and the reasons for ultimately leaving the job are very similar. Regarding the intention to leave (survey study), one category emerged that was unique: responsibilities (Qualitative job demand). The interviews revealed five unique categories: unpleasant team atmosphere (lack of social resource), lack of challenges, concerns about autonomy (lack of work resources), and lower commitment and lower performance (outcomes).

Job demands

The job demands mentioned were reasons related to qualitative (emotional and mental demands), quantitative (workload) and organisational aspects of their work.

Qualitative demands

Participants indicated that it was difficult to balance their work and personal life, which was reflected in the difficulties with planning their work and personal time. The perception that they did not have enough time and attention for their own children and the feeling of being less involved in organisational tasks within the practice led to work-life conflicts.

I thought it was really difficult when, after a night shift, my daughter wasn't at day care and I had to look after a baby. I couldn't sleep and I also had to rush to my father to care for him, no sleep, as I said... and then the additional management tasks. If a shift was quiet, I would complete those as well during my shift. So I went to my manager at some point and said: I simply cannot handle it any more like this. (P14)

Being on-call and working in community care with shifts of 24 hours or more were reasons for participants to quit. The burden of availability, irregular working hours (never knowing when you need to work) and having 24/7 shifts were reasons for leaving in the long run. Some older participants particularly found it difficult working night shifts. They indicated that they needed more time to recover from the hours they worked at night.

At one point, the night shifts were causing me so much stress that I was suffering from stomach ache two days in advance. Eh, so almost all week I would have this sort of brick in my stomach, because I had to do another night shift… how was I going to do this? After the night shift, I then had to do home visits for 12 hours on end, I don't know, just going on and on for 24 hours... (P06)

The life events were related to events in a participant's personal life that interfered with their work as a midwife. For instance, a pregnancy-related life event was making it hard for a participant to work with pregnant women. Traumatic events during shifts, such as the resuscitation of newborns and death of newborns, affected their work. One midwife said that the impact of this event affected her self-confidence. She doubted whether she could handle the enormous responsibility of working as a midwife.

Quantitative demands

Work overload was mentioned as a quantitative job demand related to leaving the profession. Participants stated that they were overloaded during their shifts, i.e. making home visits, supporting home births and receiving a high level of phone calls affected their wellbeing.

So, during your shift, these are all things that you get asked to do: Can you arrange this, can you do that, can you, this lady feels, eh, less movement, but my consultations are running really late, can you go and have a look at her? (P03)

Organisational demands

Participants mentioned two different organisational demands: setting up partnerships, and the amount of administrative and organisational tasks. Setting up partnerships refers to the efforts it took to agree with colleagues about work procedures and collaboration within the practice. Building up an organised practice took time and effort, to reach consensus about work procedures. Furthermore, participants felt that the time spent on administrative and organisational tasks had increased over the years. Increasing tasks at the organisational level, such as regional meetings, meetings with insurance companies and financial matters of the practice were perceived as overshadowing their work. They experienced this part of their work as interfering with the more satisfying aspects of the profession; working with pregnant individuals.

And then there were all these new things and at one point I thought, I just don't want to do this anymore. I thought, I don't feel like changing anymore, it is already costing me so much energy. I am not going to spend time reading up on care standards and... I don't want this anymore, I don't want any more changes, I no longer had the energy to change. (P04)

Lack of job resources

Job resources relate to social, work, organisational and developmental resources. During the interviews, a lack of job resources was perceived as a deficiency.

Lack of social resources

Participants perceived a lack of back-up from colleagues in their team, an unpleasant team atmosphere and a lack of professional recognition. They felt dissatisfied in terms of collaboration with colleagues. This related to the problems of collaboration between the team of midwives in community care practices and to collaboration problems between community care and hospital care.

Regarding the lack of support from colleagues in organising their practice, participants experienced a lack of engagement with colleagues about innovations or adjustments they needed for their own wellbeing and health, for example. This lack of commitment led to feelings of withdrawal.

Just be nice to each other for once... we are all doing 24-hour or 48-hour shifts... Let's have a good look at this situation together: Is this healthy? Isn't it time to make a change? Not as in, yes, this is how we do it because that's how we have been doing it for years..., but I couldn't really identify with the group of midwives around me. (P14)

For less experienced midwives, the lack of support from fellow midwives and the lack of being able to consult with colleagues during their shift was one of the reasons for leaving the job.

What I was missing a bit was a sort of general safety, or maybe more of a culture in which, when you have just finished your studies, you are more supported by others, or it is normal to discuss cases and things. (P17)

Some participants perceived hierarchical relationships in the collaboration between community and hospital-based midwifery care. They also felt a lack of professional recognition for their position as a midwife.

I really want to work together, but only on an equal footing and everyone on their own, everyone as an expert in their own field. I am not going to tell a gynaecologist to do a caesarean, like this and this lady should be lying like that, I don't know. That is not my area of expertise. So, I don't want it the other way around either. And if that had happened but if we still would have had, this mutual respect between us, I would still have been there, yes. (P11)

A lack of work resources was mentioned as a reason for leaving the midwifery profession. This included the following: changing client demands, a lack of challenging tasks and concerns about the autonomy of midwives.

Participants perceived changes in the working context which related to a change of the needs of clients over the years. According to the participants, clients wished to have more pain relief during their births, consequently leading to more referrals for secondary care. Community midwives could therefore support fewer women during home births. They felt that they lost their clients halfway through the birthing process.

Another thing is the clients themselves... I am a very physiological thinker and to see that someone has a baby whose position has been measured with an ultrasound and then the baby turns out to be slightly bigger than expected. Then she goes to see the gynaecologist who decides to induce labour at 38 weeks. Then you'll have a baby weighing 3,500 grams, which is perfectly normal, but is struggling to come out... And then the client says they're happy they went to the hospital. (P08)

Participants also felt that their jobs had become less challenging over the years. The more experienced they became as a midwife, the fewer challenges they met in their work. Some midwives mentioned their own need for more challenging work.

Participants expressed concerns about their autonomy. They felt that their autonomy as midwives had changed over the years. National debates about integrated midwifery care, integrated funding of maternity care and changes in the organisation of maternity care affected their autonomous decision-making and practice in community care. These developments contributed to a perceived greater dependence on obstetricians and hospital midwives, resulting in a loss of job autonomy.

At the beginning, we still had a hospital in [city] with old gynaecologists and they said, I don't need to know everything you do, but I trust it will go well, and to be honest it sometimes scares me, but you can always call when something happens.

... Then you just knew, okay, I'll send this lady to them, it'll be okay. And now everyone is interfering with everyone. (P11)

Lack of organisational resources

A lack of organisational resources was seen in discrepancies in values, unfair pay, and dissatisfaction with their employment status. Participants mentioned discrepancies between their own professional values and working in practice. They initially worked towards empowering women during childbirth and supported them to cope with pain. The discrepancy between these values and their work in reality had an impact on their job satisfaction.

I was part of the workgroup on waters breaking without labour starting and was thinking, but wait, we are talking about primary care and why is maternity care here and why is the paediatrician here? Why are we even creating these multidisciplinary guidelines? … I don't like this, because then you end up with compromises in your own work, created by someone who doesn't even do this work. (P11)

Participants perceived their payment as unfair over the years as due to a lack of acknowledgement of their years of experience in terms of financial rewards.

.. and then there are these young girls who have a very decent income and I found that really unfair at one point. (P06)

Employment status was perceived as another issue leading to dissatisfaction with the job. Some participants did not opt for the self-employed status as new midwife but found that they had to when they wanted to work in community care. Working as a locum was more challenging than they had expected. Financial matters, temporary work, and dependence on their colleagues for getting more shifts as a locum were perceived as tough and dissatisfying.

Lack of developmental resources

A lack of development resources – such as career opportunities and available learning opportunities – was stated by community midwives as a reason for leaving the job. Some midwives indicated that they had to leave the profession if they wanted to gain further professional development.

And somewhere there's still this dream of mine and then I think, the experience I am gaining now, the worldwide systems and structures, if I could bring some of that back to midwifery, that's what I would really like... (P17)

Lack of personal resources

Participants indicated that their own personal characteristics were also a reason for leaving the job. They perceived a lack of flexibility and feelings of insecurity as a hindrance in terms of providing care for women. One participant described that she considered herself as unable to cope with the changes in the organisation of midwifery care. Other participants mentioned their own uncertainty and doubts about making decisions in their work. This day-to-day feeling of uncertainty ultimately led to them to becoming unhappy in their jobs.

I am thinking of an example, but I can't find it, but I had this idea that my colleagues were more capable than I was. (P02)

Outcomes

Midwives really do quit when they see no way out, when they no longer feel any possibility of adjusting work conditions, either in reducing job demands or increasing job resources.

And I always had the feeling, in those 20 years that we knew each other, that we were together and that we could solve it together. And for the first time I discovered that it wasn't about solving things together... and in the end I left the partnership. (P06)

Participants perceived changes in their performance, their work employability, and their commitment in the period before quitting their job. They felt less involved with the women they cared for and with their team. Moreover, they felt less engaged with changes in the organisation. The realisation of these feelings led some of them to ultimately make the decision to leave midwifery practice. Other participants were forced to leave midwifery due to a progressive illness or due to physical and/or psychological constraints developed because of their work. Personal life events were also mentioned as part of the decision for leaving the midwifery profession.

I can't muster up the empathy anymore. I think that, yes, maybe it had to do with grief. That I was more focussed on myself or something, not intentionally, but... (P02)

Outcomes of the narrative analyses

Participants perceived the final decision to leave midwifery practice as a process over time. They mentioned, among various other reasons, the fact that they were unable to change their job circumstances as a reason for deciding to leave the profession. A variety of factors, such as different job demands and a perceived lack of job resources sometimes combined with a lack of personal resources, contributed to leaving the profession. For example, the combination of the problems of the long shifts, the interdependence of the business partners (in this case, fellow midwives) in the midwifery practice, the changing demands of the clients and, at the same time, caring for their own families all contributed to their final decision to leave their jobs.

I already knew I wasn't going to do this forever. And I noticed the balance shifting more and more. In the beginning, the work energised me, and towards the end, it only depleted my energy. And then I really had a bit of a burnout, after that move. And even before that,

I already thought things weren't going very well. That was when I wanted to quit for a while...(P08)

DISCUSSION

This mixed methods study of midwives' intentions and reasons for leaving the midwifery profession in the Netherlands reveals that one third (32.7%) of midwives considered leaving the profession. Split into newly qualified midwives and experienced midwives, we have revealed almost the same figures. Dissatisfaction with the organisation of midwifery care and family commitments were the main reasons for their intentions to leave the job. Reasons for actually leaving the job comprised an accumulation of qualitative and organisational demands combined with a lack of work resources. Conflicts between work and home life, problems with the length of shifts and on-call shifts, a lack of commitment within the team, a lack of social support from colleagues and a lack of work resources led them to leave the profession. Illness or physical limitations and the inability to change working conditions were also reasons for leaving the job as a midwife.

Compared to international studies, it is remarkable that our findings indicate that fewer midwives intend to leave their jobs. Other studies reported rates ranging between 40% and 60%, whereas we found a rate of 34%. [2,9,10] This difference might be explained by the different work context of Dutch midwives. Previous research shows that working as an autonomous, self-employed midwife protects them from burnout symptoms, [28] and is associated with high work engagement. [16] Since most midwives in the Netherlands (about 66%) are self-employed in the community, [1] these working conditions might therefore be a reason for a substantial group of midwives to stay.

The process of moving from the intention to leave to actually leaving the job seems, in our findings, to be the result of a process in which midwives first try to adapt to their working conditions, followed by feelings of frustration over the lack of opportunities to change their working conditions. Finally, they feel less engaged in their work. This process of decreasing engagement in their work is consistent with previous research findings: less engagement led to withdrawal behaviour and decreased performance. [8,29] Potentially, this process may indirectly affect the quality of care that midwives provide.

Community midwives mentioned having problems in dealing with the changing demands of clients, which affect midwives' work resources. In the Netherlands, women's demand for pain medication during childbirth often leads to an obligatory referral to the hospital, which results in the transfer of the responsibility for the care to mother and child to the hospital-based midwife or gynaecologist. These referrals lead to

discontinuity of care, frustrating midwives in the community. From the literature, it is known that continuity of care is important for midwives if they are to intend on staying in midwifery. [30] In the Netherlands, the professional scope of midwives is limited to physiological pregnancies, births, and postpartum periods, with a strict separation between primary and secondary care including strictly defined guidelines regarding referrals. Thus, the changing client demands combined with the Dutch healthcare system and its strict boundaries lead to discontinuity of care, also leading to midwives' dissatisfaction with their work.

Another important finding was the conflict between work-life balance of community midwives in the Netherlands. This finding is consistent with a study on Canadian midwives, who felt the impact of their work conflicting with their personal lives, not the other way around. [31] In addition, being on-call and long working hours disrupt family life and cause stress and anxiety in midwives, [32] thereby reducing their wellbeing. [28] Such negative psychological reactions may lead to the intention to leave the profession and eventually to quit the profession.

Our findings also reveal an issue which has not been addressed in previous findings. Community midwives in the Netherlands are often self-employed. This means that they have their own business (midwifery practice) and, most of the time, work in collaboration with other midwives. These midwives negotiate with healthcare insurance companies about their rates and are fully responsible for managing their own practice. In general, midwives who want to work in the community have little to no choice but to become self-employed. In the literature, this work situation is considered the same as being a 'necessity entrepreneur', meaning that someone starts their own business out of necessity instead of out of opportunity. [33] Dutch midwives can be considered as necessity entrepreneurs. The research addressing the mental wellbeing of necessity entrepreneurs shows that this group has less subjective wellbeing in comparison to the general population. [34] The work of necessity entrepreneurs exhibits higher levels of uncertainty, responsibility, and complexity, which are associated with lower mental wellbeing. [35]

Another issue regarding self-employment as a midwife concerns autonomy and work involvement. Midwives, particularly those in community care, have a high degree of autonomy regarding how they want to provide care to women. Midwives indicated that they value their job autonomy and expressed concerns about the decreasing level of autonomy in the profession due to the shift towards integrated midwifery care in the Netherlands. [36] Within this system there might be a change from separate payments for

community and hospital-based care to bundled payments for maternity care collaborations. For some participants, this was one of the reasons for leaving the job.

Furthermore, we found that a lack of social resources contributed to the decision to leave the job. A lack of commitment within the team of colleagues contributed to frustrations and conflicts, which also led to increased job demands. Previous research shows that social support from colleagues is a primary contributing factor for wellbeing at work. [28,37] The lack of social resources is associated with a higher risk of experiencing a burnout, an indicator for leaving a job. [38] Not feeling supported by their colleagues, who at the same time are equal business partners, led to increased job demands, i.e., being dependent on the goodwill of business partners for adjustments in work. Previous research confirms that there is a knowledge gap regarding the role of midwives as entrepreneurs, together with being a business partner as an important social resource. [35]

Strength and limitations

One strength of this study is its mixed methods design. The findings are based on both quantitative and qualitative data among the target population of midwives in the Netherlands. By means of this design, we could study the process of the intention to leave to actual turnover from different perspectives. Moreover, respondents were able to express themselves freely in the survey because of the anonymity of this type of research technique. Within the in-depth interview, we were able to explore and deepen our data. Nevertheless, there is a possibility that participants may have given more socially desirable answers during the interview. The interviewer who carried out most of the interviews is a midwife, which could be a limitation. This may have influenced the participants, either helping or hindering them from telling their own story. However, we do not think that this led to bias because all participants completed a member check and we did not need to make any adjustments. Furthermore, the samples comprised both a representative sample of the population for the quantitative study together with a good variability in participant characteristics for the qualitative study. [1] Another strength of this study is the use of the JD-R model for the methods and analysis of this study. The JD-R model is a heuristic model that demonstrates the possibilities of identifying the demands and resources for a specific occupational group. [14]

One weakness of this study is the generalisation to midwives in other countries. In comparison to other countries, midwifery care in the Netherlands is organised differently and the population consists of a large number of community midwives. However, we believe that our results can be used internationally to refine and reorganise maternity care so that midwives can practise in a sustainable way.

Recommendations

Further research is recommended on the intentions to leave for hospital-based midwives, and on the reasons to stay for all midwives in the Dutch midwifery context. With this information, a complete overview of the sustainability of midwifery in the Dutch healthcare system can be obtained, as well as any information on how to reduce job demands and optimise work resources. In addition, we recommend distinguishing between midwives' intentions to remain in a hospital setting and in a community setting, due to the differences in work contexts.

Considering the findings of this study, we would recommend midwifery academies to pay more attention in their educational programme to the management- and collaboration skills of midwives who are focused on working in their own business, as a locum and in an organisation. Potentially, when recruiting students, midwifery academies should also encourage students who like to work both as entrepreneurs and healthcare professionals.

A recommendation for policymakers is that it is important to evaluate the optimal organisational structure, both in the community and in the hospital setting, to initiate a transition that will make the organisational structure a job resource rather than a demand. A collaboration of practice, education and research with an action research design could be useful in building a sustainable midwifery workforce in the Netherlands.

At a national and an international level, we recommend addressing the issues of retaining a sustainable workforce while taking into consideration the values of practising midwives, increasing opportunities for social support in the workplace and improving the working conditions of midwives. We advise that priorities should be given to programmes for retaining older midwives in the profession, including, for example, more flexible on-call and night shifts. Furthermore, we recommend the arrangement of care pathways in which the continuity of the care is strengthened.

Maintaining a sustainable midwifery workforce in the shift to integrated midwifery care requires a well-considered strategy. Due to the self-employment of community midwives, midwives have a great deal of control over the organization of their own practices in terms of workload and services. The shift to integrated midwifery care affects this autonomous position and therefore requires solutions that contribute to the wellbeing of the midwifery profession. The contribution of community midwives to these solutions is of great importance.

CONCLUSION

One third of midwives in the Netherlands have indicated that they wish to leave the profession. Although the international numbers regarding the intention to leave are higher, our findings are nonetheless a cause for concern. The intention to leave the job is an important indicator for actually leaving the profession. Furthermore, the mere intention to leave can lead to poorer job performance, which affects the quality of midwifery care. The intention to leave and the accumulation of more and more reasons ultimately leads to midwives leaving their profession. Based on our findings, the present challenge is the innovation of the organisational structure, which should focus on the continuity of care for women, job satisfaction for midwives and building a sustainable workforce. These innovations would ensure that women and their babies receive the best care possible.

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CHAPTER 6

Midwives' perceptions of the performance- and transition into practice of newly qualified midwives.

A focus group study

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Women and birth 2002; 36(1): 63-71

ABSTRACT

Problem: Newly qualified midwives in the Netherlands perceive the adaptation to new responsibilities as difficult due to the autonomous nature of- and required accountability for the work they face in practice.

Background: All Dutch newly qualified midwives are accountable for their work from the moment of registration while usually working solistically.

Aim: This paper explores the perceptions of experienced midwives regarding: (1) the performance- and transition into practice of newly qualified midwives, and (2) their supporting role in this transition.

Methods: The design of this study is qualitative with focus groups. Experienced midwives' perceptions were explored by means of seven semi-structured focus groups (N=46 participants) with two meetings for each focus group.

Findings: Community-based and hospital-based midwives perceived newly qualified midwives as colleagues who did not oversee all their tasks and responsibilities. They perceived newly qualified midwives as less committed to the practice organisation. Support in community-based practices was informally organised with a lack of orientation. In the hospital-based setting, midwives offered an introduction period in a practical setting, which was formally organised with tasks and responsibilities. Experienced midwives recognised the need to support newly qualified midwives; however, in practice, they faced barriers.

Discussion: The differences in experienced midwives' expectations of newly qualified midwives and reality seemed to depend on the newly qualified midwives' temporary working contracts and -context, rather than the generational differences that experienced midwives mentioned. Dutch midwives prioritised their work with pregnant individuals and the organisation of their practice above supporting newly qualified midwives.

INTRODUCTION

Dutch newly qualified midwives (NQMs) perceive their transition into practice as difficult.[1,2] NQMs are registered midwives who have worked in midwifery practice for less than three years after graduation.[1,2] Research has shown that NQMs' levels of self-confidence decrease during the first months in practice and that NQMs need support from experienced midwives.[1,2] NQMs have to adapt to their new roles and responsibilities, which is experienced as difficult.[3]

In the Netherlands, the professional education of midwives in the Netherlands consists of a four-year direct entry Bachelor of Science programme which gives access to registration, allowing license to practice. [4] Midwifery students spend a minimum of 70 weeks of internships in their four years of educational training: 42 weeks in primary midwifery care, and 28 weeks in secondary/tertiary care settings.[5] After graduation the majority of Dutch NQMs work in community practices, where they work independently and autonomously.[6] Support from midwifery colleagues seems scarce in both hospital-based and community-based settings due to the NQMs' locum status and to the unavailability of experienced midwives to collaborate with.[1,2]

The NQMs' decreased confidence levels may affect the performance of NQMs and therefore the quality of midwifery care, according to Offerhaus et al..[7] Professional performance is defined as the knowledge, skill or care possessed and applied by a registered health practitioner in the provision of regulated health services.[8] The lack of confidence might lead to NQMs who act cautiously, which ultimately leads to an increased number of unnecessary referrals to an obstetrician.[7] These referrals create discontinuity of care, leading to more interventions and higher costs.[9] Internationally, various countries organise formal support for NQMs to guarantee the quality of care for pregnant individuals.[10,11] Although support of NQMs cannot not guarantee the quality of midwifery care, previous research on NQMs suggests that structured support from experienced midwives is an effective tool to increase NQMs' levels of competence and confidence.[12-14] Positive support by an experienced midwife as a mentor leads to reassurance and safety for NQMs, promotes better performance and competence and increases positive learning experiences.[12,15] The main sources of formal support are experienced midwives who are employed within or outside the facility (mentors)[14] and informal support from the midwifery team.[16]

Different countries recognise a period wherein NQMs can build competence and confidence as autonomously working and newly registered practitioners.[3] This period is often defined as transition into practice: a foundational period at the start of a career.[3]

Previous studies in NQMs recognise the role of the working environment as a resource in this transition.[1-3] NQMs recognised this resource as theoretically important but in reality, the working environment was not always supportive. Community-based NQMs perceived working with clients as resourceful, but desired back-up from colleagues which they lacked in practice.[1] Hospital-based NQMs perceived the collaboration in a multidisciplinary team as resourceful, but they experienced a deficit in time spent working together with experienced midwives during a shift.[2] During a shift, midwives are responsible for multiple birthing suites.[2] They don't have the time and possibilities for working together in the same room.

Although Dutch NQMs in our previous studies emphasised the importance of available colleagues to feel confident in practice, it is unclear how the incumbent group of midwives perceive NQMs' performance and their transition into practice. Furthermore, it is unclear how experienced midwives support NQMs in practice and what they perceive as their own roles and responsibilities. Therefore, the aim of this paper is to explore the perceptions of experienced midwives regarding: (1) newly qualified midwives' performance- and transition into practice, and (2) their own role in supporting this transition. The following research questions were answered in this study:

1) How do experienced midwives perceive the performance of NQMs in practice?
2) What do experienced midwives perceive to be their own role in supporting NQMs' transition into practice?

This study provides insights into the transition of Dutch NQMs into practice as perceived by experienced midwives. With the outcomes, we contribute to improving the transition period and support for NQMs. Furthermore, we contribute to acquiring knowledge about the transition of NQMs into independent midwifery practices.[3]

Newly qualified midwives in the Netherlands

NQMs can choose to work in a community-based or on a hospital-based setting. After graduation most NQMs work in the community (72%) as either a self-employed midwife or a minority as an employed clinical midwife (7%). Community-based midwives hire a locum midwife for holiday-, maternity- or sick leave. NQMs work in their first years in practice mostly as a locum, before they can take a share in a partnership of midwives. Locum midwives are considered self-employed as an "autonomous professional without personnel" by the Dutch tax agency. [8] They are required to work for several different

midwifery practices to demonstrate their independence. Midwives who are hiring a replacement therefore are commissioners and not employers.

PARTICIPANTS, ETHICS AND METHODS

This study is a qualitative study, exploring the perceptions of experienced midwives by means of semi-structured focus groups. The semi-structured approach was chosen because we aimed to explore a diversity of perceptions and experiences. The standard method to report qualitative research (SRQR) was used. [17]

Theoretical framework

In this study we used the organisational socialisation theory as theoretical framework, [18] which enabled us to organise and reduce the data and allowed us to answer the research questions in more depth. Organisational socialisation is defined as 'the learning and adjustment process that enables an individual to assume an organisational role that fulfils both organisational and individual needs. [18] Organisational insiders (e.g., supervisors and peers) in this theory are important in helping newcomers adjust effectively, based on the importance of how they communicate. In this theory, organisation tactics and individualised tactics are used to reduce newcomers' uncertainty by shaping how information is disseminated and what sources of information and social resources are given. The outline of the different tactics is explained in figure 1.

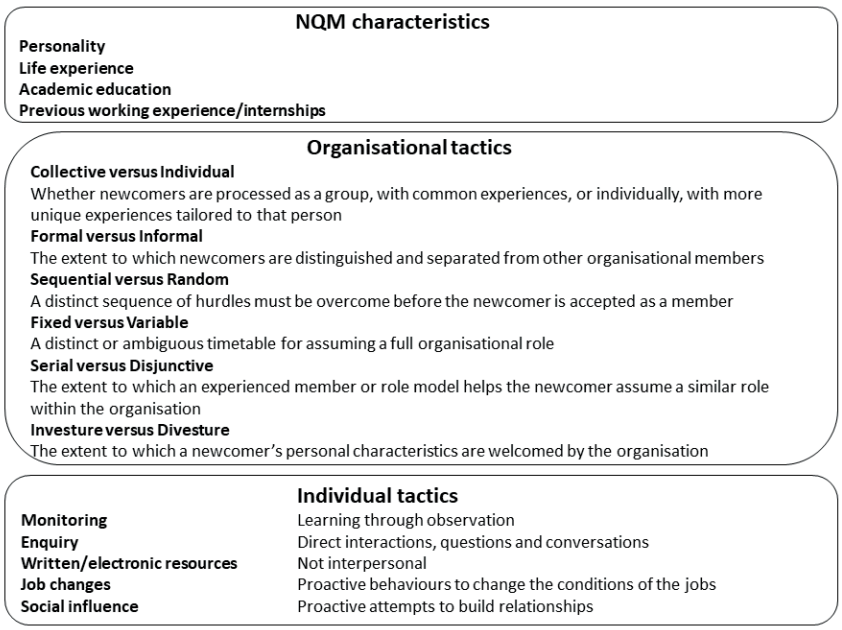

Figure 1. Theoretical framework of organisational socialisation[19]

Researcher characteristics

Three researchers, a qualitative researcher, a master's student, and a registered midwife constructed the topic list and the interview guide for the focus groups and the analysis of the data, under supervision of a senior researcher. With a combination of research experience and knowledge of midwifery practice, we put together an experienced team.

Population

In collaboration with the Royal Dutch Organisation of Midwives (RDM), seven focus groups of experienced midwives were organised in the months from September to November 2019. Participants had to be experienced midwives, who actually work in midwifery practice in the Netherlands for more than three years. These groups comprised community-based and hospital-based midwives. Recruitment of participants took place via an announcement on the weekly newsletter on the website of the RDM and the website of all three midwifery academies in the Netherlands. In this announcement midwives with an interest in the research topic were invited to participate in the focus groups. They could send an email to the RDM as indicated in the announcement. Interested midwives received an invitation letter and written information about the study.

Group interviews and topic list

We scheduled two meetings per focus group, a month apart. Each focus group consisted of 8-10 participants. The purpose of the first meeting was to explore participants' perceptions of NQMs in practice. At the end of the first meeting, we provided participants a copy of our two research papers.[1,2] These articles provided the participants with insight regarding NQMs' experiences of the transition into practice. In the second meeting we explored the needed and actual support for NQMs in practice and eventually explored measures to ease the transition of NQMs into practice. We composed a topic list and an interview protocol for both meetings (Appendix I). During the data collection, which was considered an iterative process, we made a few changes to our approach and to the interview protocol. For instance, after some of the first focus group meetings, we made sure to ask participants to write down their ideas prior to a focus group. This change allowed us to include all opinions and ideas in the discussion.

All meetings were audio-recorded and summarised. All participants received a written summary of the results of the focus group meeting they had attended. They could add

comments to the summary by email. The transcriptions of the meetings were anonymised. Furthermore, one member from each group read the whole transcript. All recordings and transcripts were stored in a secure location at the University.

Ethics

In the Netherlands, ethical approval by an ethics committee is not required for this type of research (www.ccmo.nl) which involves professionals rather than patients. All participants in the interviews gave written informed consent. To ensure confidentiality, personal data of the participants was separated from the transcripts and stored according to the data management regulations of the University of Groningen.

Analysis

We performed a thematic content analysis, starting with an inductive approach. First, two researchers open coded all the transcripts. [20] Differences in coding were discussed until a consensus was reached. In the second phase of coding, axial coding, the organisational socialisation framework has only been used to ensure that no concepts were overlooked.

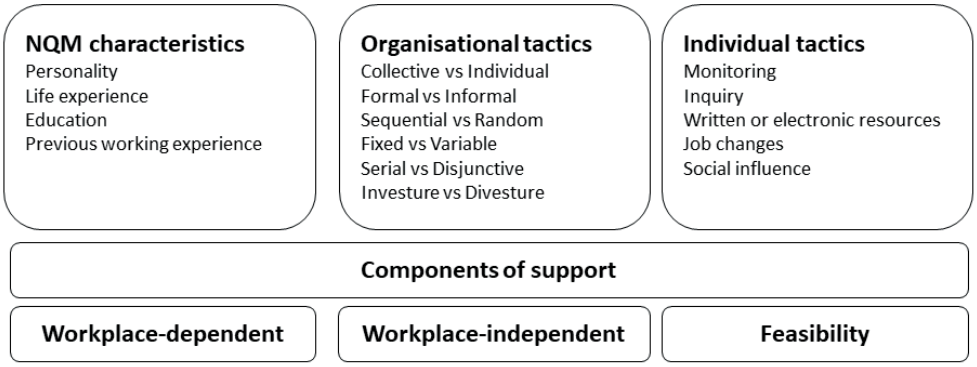

Figure 2. Initial code tree for the analysis of seven focus groups of Dutch experienced midwives' perceptions of supporting NQMs in practice

The third phase of the analysis, selective coding, comprised of dividing the categories into themes and summarising the outcomes on socialisation in practice, based on working in community-based practice and working in hospital-based practice. In the final phase of the analysis, we entered the codes into a spreadsheet, summarising the data from each transcript by category. For the analysis, we used the software tool MAXQDA 2020. In the third phase, all data was summarised in the framework matrix in an Excel spreadsheet.

FINDINGS

The characteristics of the participants are presented in Table 1. The focus groups comprised of 46 participants; 35 of whom attended two meetings. Participants worked in the community (85%), in a hospital (11%) or in a combination of the two. Participants were mainly self-employed (54%), others worked as a locum midwife (20%) or were employed (26%). Almost three out of four participants had more than 10 years of working experience (72%).

Table 1. Background characteristics of participants in group interviews

Variable	Participants N=46 (n (%))
Age	
≤ 30	7 (15)
31-40	8 (17)
41-50	17 (37)
> 50	14 (31)
Country of initial education	
The Netherlands	39 (85)
Belgium	6 (13)
Other country	1 (02)
Additional training/coaching	
Yes	12 (26)
No	34 (74)
Working context	
Community	39 (85)
Hospital	5 (11)
Combination of the two	2 (04)
Working experience	
0-3 years	6 (13)
4-10 years	7 (15)
> 10 years	33 (72)
Employment status	
Locum	9 (20)
Self-employed	25 (54)
Employed	12 (26)

Firstly, we report on experienced midwives' perceptions of NQMs in practice. Secondly, we report on the perceptions of support for NQMs in community settings and in hospital

settings. Lastly, we report participants' perceptions of desired support for NQMs and options for making support feasible in practice.

NQMs' performance

Overall, midwives perceived NQMs as well-educated practitioners with little practical experience. Midwives recognised the pre-registration education as a decent theoretical foundation for NQMs to work in practice. NQMs can provide care for pregnant individuals and are able to make decisions based on clinical reasoning. However, participants perceived NQMs' feelings of insecurity and the need for reassurance in specific situations as caused by little work experience. NQMs need to, in their opinion, learn to cope with their new roles and responsibilities. NQMs were, in their opinion, fully occupied with caring for pregnant individuals, writing reports and administrative tasks. Being self-employed and working as an entrepreneur seemed not yet within their scope of practice. Experienced midwives worried about the lack of relationship-building in practice. NQMs lacked awareness about the importance of being a team member and building a network within the midwifery practice. On the other hand, participants showed compassion for the overwhelming tasks and responsibilities that NQMs encountered in practice.

How can we make sure that [NQMs' qualities] come out? So that they don't get overwhelmed in the meantime, or that there is too much uncertainty and, therefore, they don't get there. (Focus Group (FG) 3.1)

Based on experienced midwives' perceptions of NQMs, we deduced different underlying values for NQMs' performance in practice: commitment, passion, and availability. Experienced midwives valued NQMs who committed themselves to their work, who were involved with the practice and took the initiative to perform specific tasks. Experienced midwives perceived boundary setting attitudes (such as asking for roster requirements or specific days of the schedule) as being less committed to the challenges that 'midwifery' requires in practice. Furthermore, participants mentioned that being a midwife implies being prepared to make sacrifices in one's private life.

Being able to put yourself in second place for the benefit of other things. …but I think that many students nowadays also think from a self-perspective, I am the centre of society principle. And that everything has to be attuned to that. (FG 2.2)

Participants mentioned (a lack of) passion, referring to a strong feeling and enthusiasm for the profession.

..on the other side, what it brings you, not only financially, but from what the profession entails is what I actually miss [in NQMs]. That bit of enthusiasm and passion. So perhaps we as a professional group must show our [passion]: ''Look what a wonderful profession it is. (FG 2.2)

Availability was mentioned by participants as value for working in continuity of care. Participants expected NQMs to be willing to gain work experience at, for them, inconvenient times.

…NQMs have come up with a wish list, saying: 'Yes, I want Wednesdays and I want 12 o'clock, and I want week hours but not on Saturdays', …. Then I think, you know. If you have a list like that, then you can indeed ask yourself how suitable you are for this profession. (FG 2.2)

Participants perceived midwifery as a profession that must be learned through experience. Experienced midwives mentioned that NQMs must further develop their skills by learning from practical experiences. NQMs must learn to differentiate between working according to protocols versus tending to the needs of their clients. In their views, NQMs must learn to trust the physiological processes of pregnancies and childbirth.

And they know those [protocols] off by heart, but the pitfall is that you then can't think creatively during childbirth. So, you have a childbirth that is not progressing well and then you [NQM] can't think of trying another position, we are going to try … (FG 2.2)

Participants mentioned that different personal characteristics of NQMs were demanding for their work in practice, e.g., the urge to prove oneself and perfectionism. Participants sometimes perceived NQMs as anxious in challenging situations and in need of reassurance from their colleagues.

That fear; wanting to do well on the one hand, but on the other: 'what if I do wrong, what will happen to me then?' I think that that has increased explosively over the past two years. (FG 1.1)

Transition into practice

As shown in Figure 3, a distinction was made between the two different working contexts for NQMs in practice: community-based and hospital-based midwifery. The working context showed different tactics for socialisation in practice.

Community-based practice

After graduation, NQMs must be prepared to work as a locum, whereby orientation programs are lacking. Midwives hire a locum, which implies that a locum is immediately employable. With written practical information, a locum needs to be able to work the shift, independent of the amount of work experience. Participants mentioned the importance of making enquiries before hiring a locum, setting out clear expectations and negotiating about shifts and fees. Orientation folders and information about the most frequently used protocols and addresses are perceived as necessary information for a locum (NQM) to be able to work in the practice. Unfortunately, this written information was not always available. Participants mentioned that the effort that they invested in supporting NQMs depends on the length of time for which they need a locum. If NQMs were hired for a longer period, they were more willing to support NQMs with orientation. On the contrary, some locums work in a practice for only a few shifts, whereby experienced midwives showed less commitment to supporting NQMs.

[Support] is very convenient to set up for those [locums] who work with you for a long time, but when you hire a locum for a single summer or for maternity leave, the time investment is too high, in my opinion. (FG 5.2)

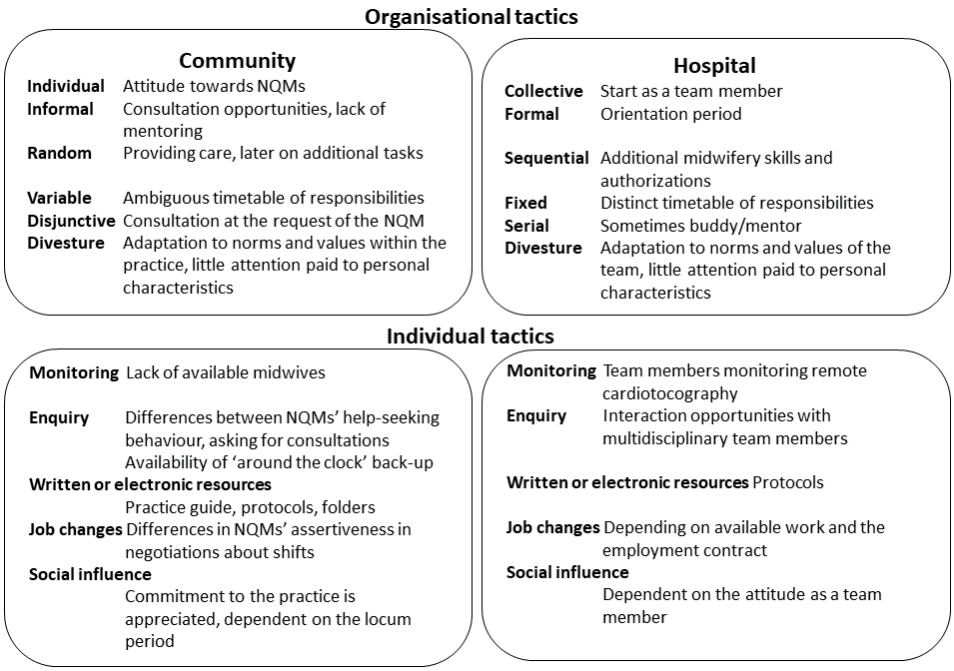

Figure 3. Organisational and individual tactics, based on perceptions of Dutch experienced midwives (N=46)

Participants emphasised that available backup from colleagues was important for NQMs' confidence in practice and therefore the quality of care that they provide. However, some participants expressed concerns about NQMs' need for backup. They suggested that midwives' autonomy requires autonomous decision-making in practice. They may ask for help, but they must make their own decisions.

Participants mentioned the importance of individual work conversations with colleagues during a shift as accommodating NQMs. Experienced midwives must be aware that NQMs in practice require an investment in time and attention during a shift.

But when you have a younger NQM as a locum in your practice, then you also know in advance that the shift handover will just take a little longer in the morning. In that case, you briefly go through some things together. (FG 3.2)

Furthermore, participants mentioned that working group meetings (weekly or monthly meetings to discuss different cases) were facilitating NQMs in their work. Due to their locum employment status, NQMs were sometimes not permitted to join these meetings. If NQMs are not permitted to participate in these meetings, they lack the opportunity to discuss the practical situations with their colleagues.

…for your locums, you are their commissioner at some point, mainly in primary care. So actually, you cannot oblige them to participate in working group meetings. (FG 3.1)

Hospital-based practice

Participants in hospital-based settings described formal orientation periods for NQMs as common practice. The duration of the orientation differed per hospital. The first period in hospital-based midwifery also showed a sequence for additional midwifery skills training and a build-up in responsibilities. Both employers and NQMs seemed to be aware of these requirements. However, in practice the orientation period was often reduced due to understaffing. Participants expressed their concerns about the lack of orientation for NQMs and the risks of leaving the job early. They expressed the important role of management towards facilitating NQMs' transition on the labour ward.

We now have someone [NQM]. I think a really good midwife, whom we have tried to initiate into practice and that has gone completely wrong, so now she's actually facing the consequences and probably has to leave. (FG 3.2)

The way in which NQMs were supported in practice differed between hospitals. Participants described workplaces that provided NQMs with a mentor or a buddy, while

other teams did not arrange specific support for NQMs. Participants expressed that they did not have time and opportunities to observe NQMs doing their work. Some of them perceived this as a pitfall of hospital-based midwifery. On the other hand, working on a labour ward provides opportunities for working in a multidisciplinary team. NQMs were provided with feedback from obstetricians and obstetric nurses, based on monitoring the progress of individuals in labour.

Components of support

Participants mentioned different objectives for support: prevention of a burnout and leaving the profession early, in addition to providing reassurance and guidance and empowering NQMs. Learning from experienced midwives is a necessity for NQMs' professional socialisation. While working in a team of midwives, NQMs can reflect on their practice and learn from the practical experience of their colleagues.

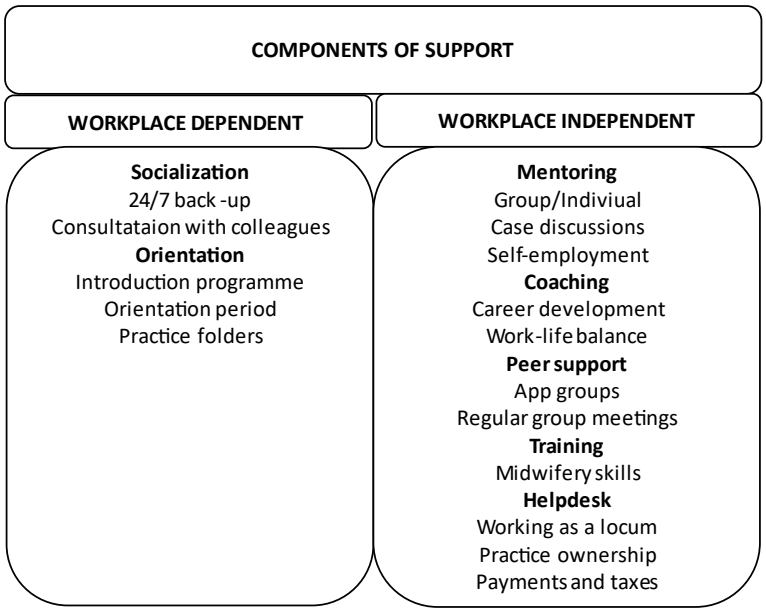

Figure 4. Components of support for Dutch NQMs, based on seven focus groups comprising Dutch experienced midwives (N=46)

Workplace dependent

According to the participants (Figure 4), experienced midwives and working teams are responsible for introduction and orientation in practice. Orientation implied the possibility for around the clock back-up from available colleagues for consultation.

Orientation in practice entailed introduction programmes for NQMs in the hospital. For community-based midwives this should include information about how to work at the specific workplace, protocols, and practical information.

So, you do the introduction of them, but if there are still problems, then I think they should have a contact person they can call. Because you can give them a whole set of protocols, but if you run into anything practical, at two o'clock in the morning or whatever, then you have to be able to call [someone]. (FG 2.2)

Workplace independent

In addition to support at the workplace, participants valued support independent from the workplace for NQMs. Support could be arranged on a regional or national level and desired for the continuous development of NQMs after graduation.

When you are working for several months that it is also there to help you develop your own vision [on midwifery]. That you think, yes okay, where am I now and what do I want. Even though you may find yourself in a situation that is not ideal right now, do you stick with it, or do you say to yourself I quit.... (FG 2.1)

Group mentoring or group coaching, focused on learning from work experiences, were mentioned as potential means of support. The preferred group composition appeared to be disputable: exclusively for NQMs or mixed groups with NQMs and experienced midwives. Peer support was also mentioned as preferred by NQMs as an important resource. Participants however expressed concerns about the lack of work experience (tacit knowledge) when only peers support each other. Furthermore, experienced midwives were concerned that exchanging negative experiences could also cause unnecessary anxiety among NQMs.

But they [NQMs] already support each other through the app [texting], they have each other on the app, yes, I mean help between air quotes. Because there are also negative experiences exchanged in these app conversations. (FG 5.1)

Learning from an NQM peer lacks an experienced midwifery view, which is, in their perception, important for NQMs' further competence development. Midwifery skills and drills training, and a helpdesk for NQM related topics could provide NQMs with the required information and at short notice.

Feasibility

Formal support programmes for NQMs in experienced midwives' perceptions, require conditions that are not yet available. Participants experienced a lack of time and finances to support NQMs.

… locums are originally there to relieve the workload. But then there is not much space to take the locum by the hand…. (FG 1.1)

They had suggestions regarding facilitating support, for example different types of payment, trainee periods or mandatory courses for the quality register. Furthermore, participants emphasised the importance of commitment from the professional bodies and hospital management for supporting NQMs.

Mentoring [a NQM] occasionally is nice, but …. you don't constantly give away your expertise for free. Because you also have more to do, then you think yes, I better do something else nice in my days of duty. (FG 3.2)

Although midwives perceived a lack of possibilities to support NQMs in practice, they indicated that if they would be facilitated with time and money there would be enough midwives willing to be trained as coaches to offer mentoring and coaching to NQMs.

DISCUSSION

This study was designed to answer two research questions: (1) How do experienced midwives perceive the performance of NQMs in practice? and (2) What do experienced midwives perceive to be their roles in supporting NQMs' transition into practice? The exploration of experienced midwives' perceptions about NQMs in practice revealed a gap between experienced midwives' expectations and the actual practice. They expected NQMs to be able to work independently and autonomously. In practice, they encountered NQMs who needed to be reassured about their actions and who were overwhelmed by the variety of tasks and responsibilities. Experienced midwives felt that NQMs were not fully aware of the importance of building up a network of work relationships and taking care of the organisation of the practice. Furthermore, experienced midwives felt that some NQMs were less committed to their work than they themselves were and that the NQMs were guarding their leisure time more closely. They acknowledged the importance of a good work-life balance but expected NQMs to take responsibility towards the continuity of care. The second aspect about experienced midwives' perception of their roles in supporting NQMs revealed two themes: supporting NQMs in orientation and overall support in the workplace. Firstly, in community-based midwifery, support for orientation was lacking or informally organised, in contrast to formal orientation periods for hospital-based NQMs. Secondly, there was a discrepancy

between experienced midwives' recognition of their roles in supporting NQMs and the actual support that they provided or wanted to provide. The high workload, independent work, and the lack of facilities to support NQMs in practice appeared to be barriers to supporting NQMs. Experienced midwives showed cooperative attitudes towards- and abilities in supporting their new colleagues. However, in practice, support for NQMs had a low priority: clients and the organisation of the practice were prioritised. Furthermore, experienced midwives expected other parties to be involved in the organisation of formal support for NQMs. Experienced community midwives, as commissioners of self-employed locum NQMs, perceived themselves as not responsible for organising- or facilitating formal support for NQMs.

This study reveals a discrepancy between experienced midwives' expectations of NQMs' performance of NQMs and the actual situations that they encounter in practice. On the one hand, experienced midwives perceived NQMs as knowledgeable and capable of caring for pregnant individuals, while on the other hand, they found that NQMs lacked autonomy, independence, and commitment. Studies have shown that NQMs need a recognised period of adjustment to meet the expectations of the work environment.[1,9,10] However, NQMs in the Netherlands work mainly as locums in community-based care.[6,21] This requires high levels of professional autonomy and competency,[21] and does not leave room for an adjustment period that leads to reassurance and confidence. Furthermore, the findings in this study on NQMs' performance show a difference between experienced midwives' expectations on NQMs' commitment to all aspects of the work and the reality in community-based practice. In a previous study based on NQMs' perceptions,[1] we found that NQMs in the Netherlands felt well prepared for providing care, but not yet prepared for running a business.[1] Furthermore, the locum position of NQMs in practice might hinder NQMs' commitment to the organisation of the practice.

In this study, experienced midwives perceived differences in work attitude between NQMs and themselves. Experienced midwives felt that NQMs were less willing to make sacrifices in their private life to provide continuity of care. However, previous outcomes about Dutch NQMs' perceptions suggest that NQMs are willing to make sacrifices for their clients, and to ensure that they have enough work as a midwife,[1] and that they show high levels of work engagement compared to experienced midwives.[25] An explanation for this discrepancy might be that experienced midwives did not notice NQMs' commitment to their clients because NQMs work alone with their clients in the

community. NQMs might be less engaged with the organisation of the practice and with their colleagues due to their temporary working contracts.[13] Participants suggested that differences between generations might also be an explanation for differences in working attitudes. Studies on generational differences in the workplace show that differences between generations X, Y and Z might exist.[22,23] For instance, the importance placed work-life balance has changed over the different generations, whereby commitment to the organisation has decreased with successive generations.[21] This study emphasises that the societal context, which is shifting towards individualisation, is more important than being part of a specific cohort. The authors prefer an intergenerational approach towards working attitudes instead of focusing on differences.[23]

Our findings show a contrast between experienced midwives' roles in supporting NQMs and the actual support that they provided for NQMs. Experienced midwives endorsed further learning and professional socialisation in practice for NQMs and valued deliberations with experienced midwives as a tool for continuous professional development. In practice, however, the provision of support for NQMs was lacking or informally organised and depended on the goodwill of individual midwives. The difference between experienced midwives' attitudes towards support and actual practice might be explained by (1) the midwifery culture and (2) the organisation of midwifery care. Firstly, the culture of midwifery in the Netherlands is historically based on providing care in the community.[21] Individual care is mainly provided by one midwife; home births are attended by one midwife, who is assisted by a maternity care assistant. Midwives in the Netherlands are basically trained to become an autonomously working midwife and less focused on teamwork. Secondly, the midwifery profession in the Netherlands does not distinguish between levels of experience, which it does for doctors.[24] The equality in midwifery between NQMs and experienced midwives might therefore function as a barrier to supporting NQMs.

Similar to the outcomes of previous studies in Dutch NQMs,[1,2] our findings on experienced midwives show that working as a locum was perceived as a barrier to support. Midwives hire a locum who can work autonomously as a midwife. Midwives commission locums, they are not their employers. Learning activities and continuous development are the responsibility of the NQM as self-employed professionals. In hospital-based midwifery, experienced midwives felt a responsibility to support NQMs. However experienced midwives did not find sufficient opportunities to adequately support NQMs in the workplace. The importance of positive support from experienced midwives has been shown to be pivotal for a successful transition into practice for

NQMs.[1,2,14,25] According to our findings, experienced midwives expected other parties to be involved and responsible for facilitating and organising formal support for NQMs. Therefore, they might underestimate their importance to NQMs' wellbeing and performance in practice.

Similar to the review on the organisational socialisation, experienced midwives acknowledged their influence in the transition of NQMs into practice from both the perspective of the individual and from the organisation.[26] By using this theoretical model, we were able to explore the role of the organisation through the various tactics. However, the concepts of the tactics were abstract, they gave us only a framework for exploring participants' perceptions on NQMs' transition into practice and for the analysis of the results.

Recommendations for research, practice, and education

Based on this study and on previous research, whereby the perceptions of NQMs and experienced midwives in the Netherlands were explored, further research is required to explore the views of other stakeholders in midwifery care on the position and support of NQMs in practice.

This study reveals that the organisation socialisation model added value to this study, due to the various tactics that we could explore. More research is recommended on the adaptation of different organisational and individual socialisation tactics for orientation periods for NQMs in practice. A detailed view on the currently used tactics may enhance the process towards the desired tactics for support.

Experienced midwives in the Netherlands must be aware of their own expectations of NQMs in practice. NQMs were seen as inexperienced colleagues while experienced midwives expected a competent locum in practice. Employers and commissioners must be aware of the specific challenges NQMs face in their first year in practice and the need for support in practice. Building confidence as a midwife, learning to be a team member, and adjusting to new tasks and responsibilities might help to smooth the transition into practice for Dutch NQMs.[3,13]

Experienced midwives' positive attitudes towards supporting NQMs in practice must be translated into a responsibility to supporting NQMs in practice. Support in practice, i.e., orientation activities and around the clock back up from colleagues, might enhance

NQMs' wellbeing in practice and thereby the quality of care that they provide. Furthermore, being a commissioner hindered experienced midwives in taking responsibility for NQMs' wellbeing in practice. Therefore, the adequacy of the temporary employment contracts and locum employment for NQMs must be reconsidered.

We recommend that midwifery academies prepare their students for the situations they will encounter in practice, the need for continuous learning in practice and the time and effort that the transition into practice will take. The RDM (Royal Dutch organisation of Midwives) should address NQMs' need for support and the barriers that experienced midwives met in practice due to the locum status of NQMs and should initiate a discussion within the profession about arranging and facilitating support for NQMs. The RDM needs to recognise the flaws of the locum position for NQMs and the effects of the absence of experience levels within Dutch midwifery on the wellbeing of NQMs.

Limitations

A limitation of our study might be the purposive sampling of our participants. All participants were interested in this topic. Therefore, there might be more variance in the perceptions among experienced midwives than we have explored. Another limitation is the sole focus on experienced midwives' views on NQMs in this study. Therefore, the outcomes of this study do not represent a view of all team members that NQMs meet in practice. For the hospital setting, the findings were based on a small sample and the sample did not include the perceptions of employers and other team members. Due to these limitations, the outcomes of this study should be treated with caution. For community-based midwifery, colleagues are also commissioners. Therefore, in this capacity they also represent the employers' view on their experiences with NQMs.

CONCLUSION

The differences in experienced midwives' expectations of NQMs and what these experienced midwives face in practice seemed to depend on the NQMs' temporary working contracts and working context, rather than the generational differences that experienced midwives mentioned. Dutch experienced midwives prioritised their work with pregnant individuals and the organisation of their practice above supporting NQMs. Midwife-to-midwife relationships for NQMs were perceived as important; however, in practice, they were informally organised or lacking. By taking responsibility for the wellbeing of NQMs and for their support within the profession, both experienced

midwives and the professional body could enhance the position of a new generation of midwives in the Netherlands.

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Appendix I Topiclist and interview protocol focus groups

Topic	Questions
NQM at the workplace	How do you perceive NQMs at your workoplace? What do they already have, what do they have to develop? What skills/developments are necessary to perform at your workplace?
Job demands and resources community/hospital based NQMs	Do you recognize the outcomes on job demands/job resources from viewpoint of your practice? Similarities/differences? What does these outcomes mean in terms of providing support?
Supporting NQMs in practice	What do you perceive as your role in supporting NQMs at the workplace? - Orientation/ onboarding in practice? - Support in practice What are the most important goals for supporting NQMs in practice? What do you perceive as desired support on NQMs?
Conditions support	What conditions are necessary? What conditions are applicable in practice?

Appendix II Interview protocol meetings

First meeting

Objectives

Participants give input from their own practical experiences and work context about content and organization of support of NQMs.

Programme

Welcome

Introduction: of focusgroup leader and participants (each three sentences)

Explanation of working method during the focus groups meetings

- Objective study
- Time schedule
- Audio recording meeting and transcriptions
- Anonimity and privacy details of participants
- Written consent and consent forms

Brainstorm

First comments and toughts about experiences with NQMs in practice. What do they perceive as positive? What do NQMs have to learn in practice?

- Job demands in practice
- Job resources: supporting NQMs in practice
- Support at the workplace

What would be possibilities in your workplace/department to support NQMs in their work?

What contribution can fellow midwives make in supporting NQMs?

What could be the benefit? For the quality of care for women, for the NQMs themselves, for the department/team.

How could this take shape in practice at the workplace/department?

What are the pros and cons of such an approach?

What would be possibilities in your workplace/department to support NQMs at work?

What contribution can fellow midwives make in supporting NQMs?

What would that bring? For the quality of care for women, for the NQMs themselves, for the department/team.

How could this take shape in practice at the workplace/department?

Second meeting

Objective

Participants in the focus group meeting provide input and feedback on the feasibility and practicability of the proposed elements of workplace (un)dependent support programmes from their own practical experiences.

Welcome

Objective this meeting

Discussion about research outcomes on NQMs (powerpoint)

Brainstorm feasible support for NQMs at the workplace

Open brainstorm in the group of eight.

Each focus group member write their suggestion(s) on a paper. All papers were collected and each paper was discussed in the group about feasibility and applicability.

Brainstorm support from outside the workplace

Each focus group member write their suggestion(s) on a paper. All papers were collected and each paper was discussed in the group about feasibility and applicability.

Conclusions

Questions / comments / evaluation of the meetings

Completion of forms travel expenses

Agreements concerning reporting of outcomes of participants

Summaries of the meetings and report RDM

CHAPTER 7

How to improve newly qualified midwives' wellbeing in practice.

A Delphi study

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ABSTRACT

Problem: Research shows that newly qualified midwives do not feel sufficiently confident and competent in their work during the period following graduation. This could impact the quality of care provided by newly registered midwives.

Background: In the Netherlands, newly qualified midwives start work as registered midwives without any formal transition support. The aim of this study is to seek consensus with stakeholders concerning viable components of support for newly qualified midwives working in midwifery care in the Netherlands.

Methods: A Delphi study was conducted among maternity care stakeholders in the Netherlands. Sixteen statements derived from previous studies were assessed in the course of two rounds. These stakeholders (N = 61) completed an online questionnaire that included spaces for opinions and remarks.

Findings: There should be an introductory support period for newly qualified midwives, involving performance feedback and backup from fellow midwives during shifts. Novice midwives should be mentored or given group coaching by internal or external midwives. Such support should be tailored to the newly qualified midwifes' needs.

Discussion: Stakeholders agreed about the responsibilities of the professional group on supporting newcomers in practice, and on the importance of providing proper orientation periods in professional practice. The importance of a stable work environment did not found consensus, while previous research suggested otherwise. This study highlighted the importance of socialisation support at the workplace, however implementation of this support is hindered by organisational barriers. Improving employment conditions and support for newly qualified midwives in policymaking could help them to achieve their midwifery quality targets.

INTRODUCTION

There are increasing concerns about the occupational wellbeing of newly qualified midwives (NQMs) in the Netherlands. Dutch NQMs start work right after graduation, as registered midwives in the community (82%), or in hospitals (15%).[1] Three out of four NQMs in the community work as a locum midwife.[1] Locum midwives work self-employed and are hired by primary care midwifery practices to cover for holiday, maternity or sick leave. NQMs need encouragement in their decision making and 24/7 backup to help them work confidently and competently in practice [2,3] However, none of these work contexts seem to meet the NQMs' support needs.[4]

Previous studies[5,6] found that NQMs' do not feel sufficiently confident and competent in their professional practice in the period following graduation.[7] This could have an impact on the quality of care they provide. [5,6] This period at the start of a midwife's career is acknowledged to be a transitional phase [8] During this time, NQMs build their competence and confidence as autonomously working, newly registered practitioners. With regard to NQPs (newly qualified practitioners), workplace issues are known to be correlated with a decreased quality of care and higher patient mortality.[9] Furthermore, in the Netherlands, Offerhaus et al. suggested that insecurity and a lack of confidence on the part of NQMs could cause them to choose safer options. This leads to operating on the safe side, and, in turn, might explain the rising referral rates to secondary care seen in low-risk women during labour.[10]

In the Netherlands, NQMs feel that their transition to professional practice is very tough, whether in the community or in hospitals.[2,3] NQMs lack work experience in professional practice and need to develop routines. Dutch NQMs start work straight away as registered midwives, which means that they are fully responsible and accountable for the care they provide to their clients.[11] In addition, many find it difficult to transition from working with backup from a supervising midwife to working autonomously. Furthermore, aside from caring for their clients, NQMs must perform the numerous organisational and administrative tasks involved in everyday practice, all of which are new to them. [3] In the hospital setting, NQMs must learn to work partly autonomously and partly under the supervision of an obstetrician. In addition, they must also learn to care for several clients at the same time, in different delivery rooms. This requires a good overview of the situation and the ability to delegate tasks to obstetric nurses.[2]

Previous studies revealed that Dutch NQMs felt there was a lack of support during their transition into professional practice.[2,3] In the community, there are no orientation programmes for NQMs, nor are there introductions to specific workplaces.[3] In

community practices, their position as a locum offers limited options to collaborate with fellow midwives.[3] In theory, hospital settings do include formal orientation programmes, however such programmes are often impacted by staff shortages.[2] Also, hospital-based NQMs need (but often do not have) an opportunity to work alongside fellow midwives, who can then act as role models and mentors or buddies.[2]

Studies in other countries have shown that support for NQPs has a positive impact on their wellbeing in practice. Introductory and orientation programmes have a positive impact on job satisfaction and commitment to the organisation, while preventing early turnover.[12,13] Transition support influences job satisfaction,[14-17] enhances feelings of self-confidence and competence,[18] decreases stress[16,17] and prevents early departure from the job.[16,17] This support is particularly effective when it involves a range of elements, such as training, observation, contacts with peers and mentoring.[14,16,19] In the Netherlands, there is no formal transition support for NQMs.[4] However, a recent study among Dutch midwives suggests that they are aware that NQMs need support and that they are willing to offer it, provided that they are given the means to do so.[4]

Little information is available concerning the transition into community-based practice.[7] However, 82% of Dutch NQMs work in community practice,[1] so this is an ideal opportunity to study support for practising NQMs. Based on our current knowledge of effective transition support and on the recognised need to support Dutch NQMs in their professional practice, the aim of this study is to explore stakeholder consensus concerning viable components of support for NQMs working in midwifery care in the Netherlands.

Research question

Which components of support do stakeholders deem to be appropriate, in terms of improving the wellbeing of NQMs in Dutch midwifery practice?

The outcomes of this study will provide us with a range of viable and applicable components of support for NQMs that are endorsed by a representative sample of stakeholders, and that professional maternity care organisations can implement in midwifery care in the Netherlands.

PARTICIPANTS, ETHICS AND METHOD

This qualitive study was conducted using a Delphi technique.[20] This technique is defined as a multi-stage survey designed to achieve consensus among a group of experts on a given issue where none previously existed, or where there was uncertainty or lack of

evidence.[21] As they are not hampered by group dynamics, the participants in a Delphi study can all contribute equally to the discussion. This method's advantages include anonymity, iteration, controlled feedback and the statistical aggregation of group response. This study was reported in accordance with the CREDES guidelines.[22]

Theoretical framework

The theory of organisational socialisation theory was used as a framework for this study about transition into professional practice. Organisational socialisation is defined as 'a learning and adjustment process that enables an individual to assume an organisational role that fits both organisational and individual needs' (p. 6).[23] Based on this theory, we explored organisational and individual tactics in a previous study of support for Dutch NQMs.[4] These different tactics were operationalised in components of support according to this study on actual and desired support for NQMs, as shown in Figure 1. Figure 1 shows support in the workplace, broken down into workplace-dependent support and workplace-independent support. The latter form of support takes place which was executed outside the workplace.

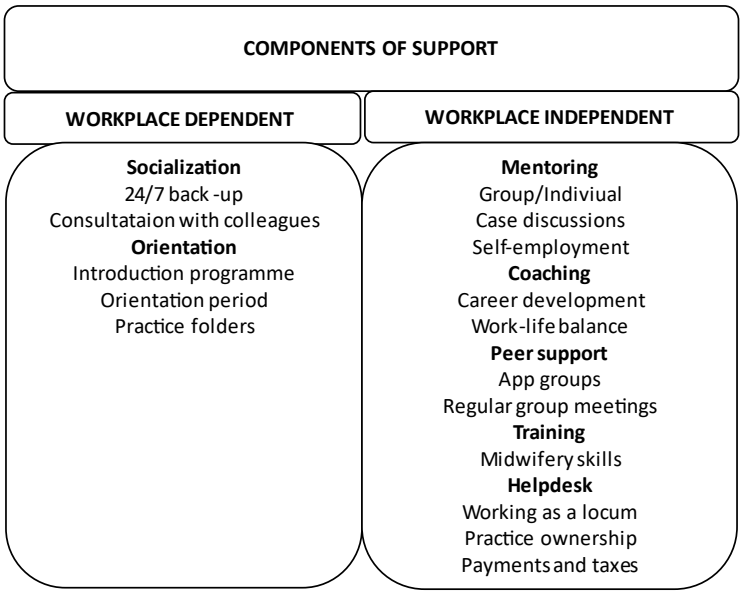

Figure 1. Components of support for NQMs[4]

Socialisation and orientation are workplace-dependent components of support, in which back-up by – and consultation with – fellow midwives helps newcomers to meet the expectations of that specific workplace (practice/organisation). Mentoring is defined as

support by an experienced professional, who provides guidance to a less experienced professional in dealing with work-related issues.[24] The mentor has a detailed knowledge of the relevant field of expertise and/or workplace. Coaching is defined as a form of development in which an experienced individual supports a learner or client, helping them to achieve a specific personal or professional goal by providing appropriate training and guidance.[24] The coach is experienced in the field of coaching/training and personalised learning.

The researcher's characteristics and competencies

The researcher (first author) is an educator in the field of midwifery and is experienced in the use of both qualitative and quantitative research designs. For several years, the researcher has studied the experiences of NQMs as they transition into professional practice, so the possibility of bias does exist. The possibility of bias is reduced by the supervising team on this study, which consist of researchers with different backgrounds. Accordingly, the various phases of the study and its findings were discussed by a team of experienced researchers (other three authors). They also were familiar with the use of the Delphi technique.

Participants

Participation was restricted to professionals in the field (NQM or midwife) or to members of relevant organisations or institutions in maternity care.[25] To ensure that this group was representative, we included stakeholders working in different regions of the Netherlands. First, a stakeholder analysis (Appendix I) was conducted to identify stakeholders in midwifery care. A list of Delphi panel participants was compiled from (1) the primary stakeholders concerned: hospital employers/managers, practice owners in community-based midwifery, experienced midwives (hospital-based and community-based), NQMs and (2) the secondary stakeholders concerned: obstetricians and staff members of the Royal Dutch Organisation of Midwives (RDM). Participants were recruited via the networks, all three midwifery academies in the Netherlands, the RDM and via snowballing. Invitations were sent to potential participants by email. These contained information about the study, the aim of the study and what was expected of participants. All of the participants were informed that their participation in a maximum of three rounds of the Delphi study would involve a timeframe of three to six months.

Ethics approval and consent to participate

The medical ethical review board of the University of Groningen in the Netherlands has declared that this study fulfil all the requirement for patient anonymity and has followed the regulations for publication of patient data (reference: M23.309800).

All participants gave prior written informed consent. To ensure confidentiality, the participants' personal data was separated from the outcomes and saved according to the University of Groningen's data management rules.

Conducting statements and questionnaires

The members of the research team formulated initial statements based on Figure 1 and based on a literature search for effective support for NQPs. In the course of that search, systematic reviews and meta-analyses on transition support were studied and summarised (Appendix II). We formulated one or more statements per component of support (Figure 1). Questions were also added about stakeholders' background, working context and managerial responsibilities. Sixteen statements were pilot tested among a group of 10 researchers and lecturers, all with a background in midwifery practice. They were asked to comment on the clarity of the statements and on the time taken to complete the questionnaire and to provide feedback on the statements. Based on the feedback provided by all 10 participants, we reformulated the text of the statements and added background information to make them clearer to participants.

In Round 1, further information was added in the form of hyperlinks. This included a document containing background information on research outcomes for practising NQMs, plus definitions of the terms used. Each statement included two questions: one about importance and one about applicability in practice. Each question used a five-point Likert scale (strongly agree to strongly disagree). After each statement, a space was provided for the participants' feedback or remarks. In a separate question, the participants were also required to identify the most important and least important statements.

Data collection

The various data collection steps are shown in Figure 2. In an online environment (Qualtrics XM), the participants were invited to review various written statements and questions and to provide the research team with informed consent. In Round 1, Qualtrics sent an email with a personal link to each participant directly. After two weeks, Qualtrics issued reminders to any non-responders in the form of a personalised email and personal link. After three weeks, any remaining non-responders received an invitation from the

first author in the form of a personal email and personal link to Qualtrics. The invitations and reminders used in the second round were equivalent to those used in Round 1.

The questionnaire used in the second round was based on statements on which there was no consensus. In Round 2, participants were given the opportunity to first read the outcomes of Round 1 via a hyperlink in the questionnaire (Appendix III). Round 2 did not include any questions about participants' background information, as the stakeholders involved were the same as those in Round 1.

Analyses

For each round of the Delphi study, the participants' personal characteristics (age, workplace, years of experience) were listed, together with the response rate. A thematic content analysis of the remarks and feedback received during Round 1 was conducted in MaxQDA 2022. Details of the response rate and frequencies per variable were reported. We used the definition of consensus shown in Table 1. Consensus per statement was deemed to have been reached if importance was 70% or higher on agreement (agree/strongly agree) and if applicability had a median score > 4 and interquartile range $\leq$ 1. Furthermore, no consensus was deemed to have been reached if remarks about the statement involved contradictory or inconsistent arguments. [21] The analyses of the quantitative results were performed using SPSS 27.

Table 1. Decision table for consensus on the statements

Importance	Applicability	Remarks	Conclusion
> 70%	Median $\geq$ 4 IQR $\leq$ 1		Consensus
> 70%	Median $\geq$ 4 IQR $\leq$ 1	Contradictory remarks/ inconsistencies	No consensus
> 70%	Median $\leq$ 4 IQR > 1		No consensus
$\leq$ 70%	Median $\geq$ 4 IQR > 1		No consensus
$\leq$ 70%	Median < 4 IQR > 1		No consensus

FINDINGS

Procedure

At the start of the study, 61 stakeholders agreed to participate and were invited to complete the questionnaire. The response rate in the first round was 92% (N = 56). In

the second round, 61 stakeholders were invited to participate. One participant withdrew its participation at the start of the second round. In Round 2, 52 of the participants responded (response rate: 87%).

The two rounds of this Delphi study are shown in Figure 2. Two subsequent rounds of statements were sufficient to reach consensus on 13 statements. In the first round, consensus was reached on seven statements. In the second round, nine reformulated statements were submitted to the panel. Consensus was achieved on six statements. Based on the responses received in Round 2, we concluded that there was little likelihood of consensus being reached on the three remaining statements, due to strong disagreement among the respondents. Accordingly, we decided to dispense with a third round.

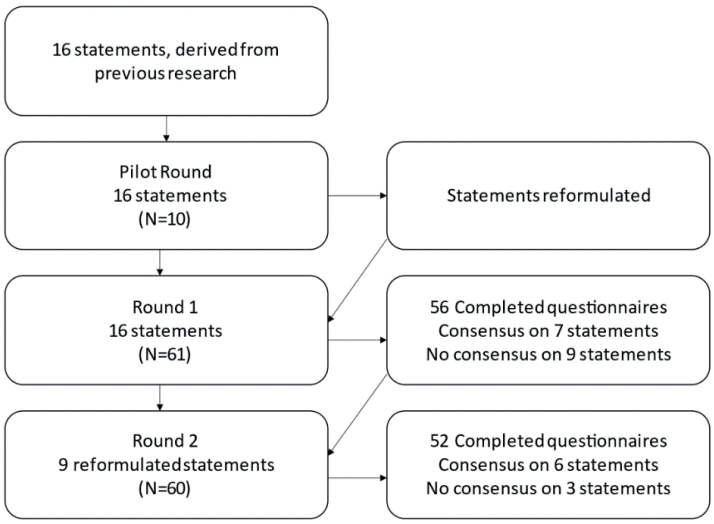

Figure 2. Flowchart of the Delphi study among stakeholders on NQMs in midwifery care

Table 2 lists the characteristics of 56 participants who completed the questionnaire in Round 1. These individuals vary in age distribution, in years of experience, in their responsibilities as an employer and in region. The participants were mostly midwives (79%). Half of the group had responsibilities as an employer (50%) and almost 75 % worked in community-based midwifery. Almost 75% of our participants were self-employed, either as a practice owner or as a locum midwife.

Table 2. Characteristics of the Delphi study's participants (N = 56)

Characteristics	Participants (n, (%))
Age	
< 30	17 (30)
30-39	17 (30)
40-49	12 (22)
≥ 50	10 (18)
Profession	
Midwife, practice owner	27 (48)
Midwife, employed (or self-employed)	19 (34)
Manager/employer	5 (9)
Obstetrician	1 (2)
Staff member	4 (7)
Working context	
Community	43 (75)
Hospital	10 (18)
Other	4 (7)
Years of work experience	
0-3	11 (20)
3-10	15 (27)
10-20	18 (32)
20+	12 (21)
Responsibilities as employer/manager	
Yes	28 (50)
No	28 (50)
Employment status	
Locum	14 (25)
Self-employed	29 (52)
Employed	10 (18)
Not answered	3 (5)
Region	
North	19 (34)
Middle	31 (55)
South	6 (11)

The findings of these two rounds are presented in Table 3. The statements on which consensus was achieved are coloured green while those in which no consensus was achieved are coloured red, according to the decision table (Table 1).

Round 1

Consensus was reached on statements 2, 3, 7, 8, 11, 13 and 14 (Table 3).

The participants highlighted the importance of NQMs, indicating that they see NQMs as team members of equal standing, even though NQMs are not yet fully functional in their professional role.

No consensus was reached on statements 1, 4, 5, 6, 9, 10, 12, 15 and 16 (Table 3). The analysis of the remarks per statement produced the following findings: The participants commented that, in community practice, there are insufficient opportunities to give locum NQMs a proper introduction (Statement 1). Several participants remarked that, because locum midwives work with billable hours, introductory programmes would be too costly.

The participants indicated that, for NQMs, the ability to choose their workplace was more important than a stable workplace (Statement 4). They pointed out that a varied range of working environments are beneficial to an NQM's development.

The participants did not prioritise the benefits of a regional commitment to supporting NQMs (Statement 5). In their remarks, they questioned the importance of such commitments.

The participants' remarks revealed that providing backup for NQMs in community practice was not a viable option (Statement 6). Backup requires midwives to be available 24/7, which is impossible in a small practice. The participants also stated that a backup period of one year would be too long, and that arranging for backup facilities imposes an increased workload on practising midwives.

Table 3. Findings from Round 1 (N = 56) and Round 2 (N = 52) of the Delphi study, including statements, importance (Imp.(%)), applicability (Appl). (median and interquartile range (IQR)) and consensus, representing stakeholders in midwifery care in the Netherlands

No.	Statement Round 1	Imp. (%)	Appl. (Median, IQR)	Consensus
	Workplace dependent			
1	Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract (e.g. temporary contract or locum).	91	4/1	Discrepancies in remarks
2	Every workplace should provide newly qualified midwives with clarity on tasks and responsibilities.	96	4/1	Yes
3	A newly qualified midwife must be treated as a full team member because this contributes to their involvement in the workplace and to their self-confidence.	93	4/1	Yes
4	To create a stable work environment, every newly qualified midwife should work in a salaried job at a workplace for their first year.	16	3/1	No
5	Each newly qualified midwife should only work in one VSV (*verloskundig samenwerkingsverband*; regional maternity care partnerships) in their first year after graduating.	43	3/1	No
6	In the first year after newly qualified midwives graduate, they should have a fellow midwife colleague who is available for consultation and/or backup.	91	4/1	Discrepancies in remarks
7	Newly qualified midwives regularly get feedback on their performance from a partner/manager.	88	4/1	Yes
	Workplace independent			
8	In the first year after newly qualified midwives graduate, they receive facilities (for training/coaching) to fully master their profession.	79	4/1	Yes
9	In the first year after a newly qualified midwife graduates, they must take part in a transition programme to get a good feel for the field.	43	3/2	No
10	In the first year after newly qualified midwives graduate, they have a mentor at their workplace whom they can consult about all sorts of work situations.	75	4/1	Discrepancies in remarks
11	During newly qualified midwives' first year in practice, they all have a guiding peer support group to ensure that they will continue to learn and develop.	73	4/1	Yes
12	Newly qualified midwives all have a mentor outside their own workplace, who can support, coach, and advise them in work matters.	64	4/1	No
13	Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).	86	4/1	Yes
14	The university of applied sciences (HBO) Bachelor's programme in midwifery is responsible for well preparing all VIOs (*verloskundigen in opleiding*; midwives in training) for them to start as professionals in birth care.	97	4/1	Yes
15	The university of applied sciences (HBO) Bachelor's programme in midwifery is partly responsible for guiding newly qualified midwives in their first year after graduation.	54	3/2	No
16	The second half of the university of applied sciences (HBO) Bachelor's programme in midwifery is offered in dual form, whereby the student partly follows an educational programme and partly works as a midwife in training (VIO, *verloskundige in opleiding*).	71	4/1	Discrepancies in remarks

No.	Statement Round 2	Imp. (%)	Appl. (Median, IQR)	Consensus
Workplace dependent				
1	Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract. If the midwife is a locum or is self-employed, their time spent on this must be compensated.	92	4/0	Yes
2				
3				
4	Newly qualified midwives work better in a stable work environment, and so they should only be deployed for locum periods longer than three months in their first year after graduating.	54	3/2	No
5	Newly qualified midwives should preferably work within a VSV in their first year so that they work with stable collaboration partners and with only one set of protocols/agreements.	65	4/1	No
6	Within a VSV, a backup staff member/colleague is always available to newly qualified midwives during their first year after graduating for consultation and/or to act as a sparring partner.	87	4/1	Yes
7				
Workplace independent				
8				
9	Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).	96	4/0	Yes
10	In the first year after newly qualified midwives graduate, they are entitled to guidance (through supervision, a mentor, a buddy, or another form of guidance) to be able to spar about all sorts of work situations.	89	4/0	Yes
11				
12	If desired, newly qualified midwives should have access to a mentor outside their own workplace, with whom they can discuss work matters.	87	4/1	Yes
13				
14				
15	The profession field of midwives is responsible for guiding newly qualified midwives in their first year after graduation.	79	4/1	Yes
16	In the last two years of the university of applied sciences (HBO) Bachelor's programme in midwifery, the emphasis lies more on gaining practical experience than on theoretical education.	69	4/1	No

The participants' remarks revealed the importance that stakeholders place on the necessity for NQMs to gain work experience (Statement 9). They placed greater valued on time spent working than on training programmes for professional education and support.

When it came to mentoring, the participants had various opinions concerning the feasibility of this option (Statements 10 and 12). They stated that, in their opinion, a one-year mentoring period would be too long. Other participants commented on the aspect of financial feasibility – there are currently no facilities for mentoring and support. Others wanted to link up with existing consultations in professional practice, in terms of discussing cases in midwifery practice.

The participants also commented on the importance of the role played by the profession as a whole in supporting NQMs, as opposed to the part played by academies (Statement 15). According to participants, the academies are responsible for support until graduation. After graduation the professional group is responsible for providing support for NQMs. The participants stated that giving student midwives employment status in their final year (Statement 16) is not a viable option. Nor did they express any desire to make major changes to the midwifery curriculum.

Round 2

In Round 2, consensus was reached on six of the nine statements. The findings show that consensus was reached on responsibilities (Statements 14 and 15). The participants agreed that while the academies are responsible for preparing undergraduates for work in everyday practice, it is the workplace that is responsible for introducing graduates to professional practice. The stakeholders feel that the workplace is responsible for clarifying NQMs' tasks and responsibilities (Statement 2), for providing feedback on their performance (Statement 7) and for organising backup facilities for NQMs (Statement 6).

No consensus was reached regarding the importance and applicability of the NQMs' need for a stable working environment (Statements 4 and 5). Nor was there any consensus regarding curriculum changes designed to increase the number of placements in the final year (Statement 16).

Table 4. Components of support for NQMs, based on stakeholders' views on responsibility in midwifery practice in the Netherlands.

Component	What	When	Responsibility
Workplace dependent components of support			
Socialisation	Backup	First year	Regional collaborations Midwives
	Collaborating with an experienced colleague	First weeks	Manager/practice owner
	Feedback on performance	First year	Manager/practice owner
Orientation	Incremental increases in tasks and responsibilities	First few months up to one year	Manager/practice owner
	Practical arrangements Introductory meeting Practice folder	First shifts available	Workplace
Workplace independent components of support			
Mentoring	Personal development as a fully functioning midwife, learning from experiences in practice	First year	RDM facilitating trained mentors, arranged in Quality Registry
Group coaching	Learning from experiences in practice	First year	RDM
Stable working environment	Safe learning and working environment	First year	RDM prepares arrangements/policy
Preparation for professional practice	Issues regarding work as a midwife, including hospital- and community-based work	Fourth year of Bachelor's programme before graduation	Midwifery academies

DISCUSSION

The aim of this Delphi study was to reach consensus among stakeholders in midwifery care in the Netherlands concerning important and applicable components of support for practising NQMs. The stakeholders agreed that orientation and socialisation in professional practice are the responsibility of the workplace. Regardless of the type of employment involved, the practice or organisation must provide NQMs with an introductory period, performance feedback and backup from fellow midwives during shifts. The stakeholders felt that mentoring is important for NQMs. Each NQM deserves mentoring or group coaching by a midwife (from the workplace itself of external). Consensus was reached about the importance of trained mentors and about providing mentoring facilities in professional practice. According to the stakeholders, it is important

to provide support based on the needs of NQMs and to offer them a range of components of support. The stakeholders felt that the profession as a whole should be responsible for mentoring and coaching. While the stakeholders felt that a stable workplace, which implicates a period of a year whereby a NQM work in one region, was applicable in practice. They did not reach consensus regarding its level of importance. Nor did they reach consensus on longer-term (> 3 months) employment commitments for NQMs, on importance or on applicability. The stakeholders also felt that it is the academies' responsibility to prepare undergraduates for professional practice. No consensus was achieved concerning modifications to the curriculum with regard to alternative placement arrangements.

Socialisation within the organisation/practice

We will consider four different components of the socialisation process within the organisation. [23] As stated in the theoretical model, organisational socialisation enables newcomers to use these components to help them adapt to their new role. Firstly, they need fellow midwives at the workplace, secondly NQMs need around-the-clock backup, thirdly they need feedback on their performance and fourthly they need a stable working environment. With regard to the first component, the stakeholders agreed on the importance of providing NQMs with support in the workplace. However, previous studies on NQMs show that NQMs lack sufficient support and that – in both hospital- and community-based settings – they spend insufficient time collaborating with fellow midwives.[2,3] Previous studies have also showed that NQMs need fellow midwives as role models and for purposes of consultation.[2,3,7,26] The stakeholders in this study recognised NQMs' needs. In their remarks on this statement, they indicated that formal consultation meetings with the teams might be one way of meeting these needs. The midwifery profession as a whole might be willing to provide support in the context of existing collaborative meetings, from an organisational standpoint. From the NQMs' point of view, this might not provide the support they need. This finding appeared to resemble the findings of previous studies into newcomers in independent practices.[27] Newcomers reported that working as a locum and therefor engaging with multiple sites led to inadequate opportunities to access meaningful long-term clinical relationships. Furthermore, organisational socialisation in professional practice needs more tailoring, to meet the organisation's needs and those of the newcomers.[23]

The second socialisation component concerns around-the-clock backup from fellow midwives in professional practice. The stakeholders agreed on the importance of backup for NQMs. However, they only considered backup to be applicable if responsibility for

this facility was shared among regional maternity care partnerships (VSV). The stakeholders' willingness to provide backup appeared to be in line with NQMs' needs for around-the-clock backup, to enhance their self-confidence and to enable them to provide safe care.[3] However, it might be difficult to organise this in practice. Without a firm commitment at the socio-political level, it will not be possible to provide backup for all practising NQMs.[28] The Royal Dutch Organisation of Midwives can enhance this implementation by creating policies and resources that emphasise the importance of backup facilities that enable NQMs to provide high quality midwifery care in the community. This could make it easier to implement support for NQMs at local or regional level.

The third component of socialisation indicates that it is the employer's responsibility to communicate details of tasks and responsibilities. The stakeholders in this study agreed on the importance of informing NQMs what is expected of them, in terms of tasks and performance. The outcomes suggest that providing clarity about their tasks, roles and responsibilities can help to prevent newcomers becoming frustrated or demotivated.[14] Previous studies showed that, in practice, there is no steady build-up of NQMs' tasks and responsibilities, nor do they receive feedback on their performance.[2,3] The views of midwives concerning their position with regard to NQMs and the associated impact on their workload seemed to pose problems for the organisational socialisation of NQMs in practice. Midwives' opinions regarding their role as practice owners who is more a commissioning agent rather than an employers, prevented them from acting as supportive managers.[3,4] By accepting the responsibilities towards supporting NQMs in practice, as shown by the commitment among stakeholders in this study, a step towards improving the working conditions of NQMs in maternity care can be taken.

The fourth component of the socialisation of practising NQMs concerns the importance of a stable working environment. Although the importance of a stable working environment for NQMs is widely recognised,[2,3,8,29] there was no consensus on these statements among the stakeholders in this study. In Dutch midwifery practice, three out of four NQMs start their career as a locum (self-employed) midwife in community-based midwifery, which implies working in different practices and therefore not a stable work environment.[1] In hospital-based work environments in the Netherlands, most NQMs have temporary employment contracts. This lack of a stable working environment hinders an NQM's development, and makes it difficult for them to request help.[27] The stakeholders in this study may have underestimated the importance of a stable working environment for the wellbeing of practising NQMs. Another explanation might be the

organisational barriers in practice to implement stable employment arrangements for NQMs due to a history of autonomous and independent working midwives.[30]

Orientation in the workplace

In this study, as in previous studies into NQMs,[2,3] the stakeholders felt that, in practice, a proper introduction in the workplace is both important and applicable. In the first round, however, the stakeholders remarked that, in practice, this might not apply to community-based NQMs who are employed as locums. As self-employed midwives, locums face an organisational barrier in the form of hourly billing, which would make an introductory period far too costly. Consensus was achieved in the second round, when we reformulated the statement to include compensation for midwives who introduce NQMs to professional practice. Organisational barriers and midwives' opinions regarding locum midwifery tend to impede support for practising NQMs. This finding resembles those of a previous study concerning support for practising NQMs, in which midwives were only willing to support NQMs if they were given the means to do so.[4]

Mentoring/group coaching

Aside from workplace considerations, the stakeholders did reach consensus on support for NQMs in the form of mentoring or group coaching. Previous findings on Dutch midwives produced similar outcomes – experienced midwives feel that NQMs need to learn from experience in practice, coupled with mentoring, as that enables them to develop a good overview of their tasks and responsibilities.[4] Thus, while this study shows the recognition of NQMs' need for further professional development as midwives, no such facilities have yet been put in place. The situation regarding formal transition support is very similar. Systematic reviews of transition support for NQPs[14,16,17] show that effective transition support involves combining professional practice with mentoring and training.[14,16,17]

Preparation for professional practice

Midwifery academies are responsible for preparing undergraduates for their future career, according to stakeholders in this study. This resembles the findings of a study into effective support for Newly qualified healthcare professionals.[31] However, NQMs in the Netherlands have to be prepared for the issues they will face in both community-based and hospital-based working contexts, instead of focusing purely on community-based midwifery.[2] Furthermore, the commitment on the educational responsibilities to prepare students properly does not eliminate the need for organisational socialisation.

The latter process takes place in the workplace, after graduation, and is the responsibility of that workplace.

Limitations and strengths

One limitation of this study might be the limited generalisability of our findings to midwifery contexts in other countries, due to the distinctive way in which midwifery is organised in the Netherlands. However, support in community-based midwifery features prominently in our findings, so these may well be applicable to community-based NQMs working in other countries

One strength of this study was the response rate in both Delphi rounds. This supports our view that the study is a true reflection of the opinions held by the midwifery workforce in the Netherlands. Another strength of this study was the online version of a Delphi study, which demanded very little of the stakeholders' time and effort.

Recommendations

The sustainable implementation of components of support for NQMs in midwifery practice in the Netherlands requires collaboration at both national and regional level. NQMs have to work according employment contracts in their first year in practice, instead of working self-employed as a locum. Changes in the employment conditions will improve NQMs' self-confidence and competence in professional practice. Therefore, the implementation of support must be considered at both regional and national level.[28] Together with its members, the RDM could take the lead in policymaking with regard to support for NQMs, with a view to enhancing the quality of midwifery care and developing a sustainable workforce.

At the level of organisational implementation,[28] the various regional maternity care cooperative groups should take responsibility for providing around-the-clock backup for NQMs. Furthermore, NQMs must be willing to approach back-up in the region for help with implementing around-the-clock backup. Moreover, practice owners and hospital-based managers should create stable employment conditions for NQMs within the region. A subsidised implementation plan should be drawn up (with the RDM taking the lead) to help the various regions implement stable employment conditions for NQMs, together with support for all NQMs.

CONCLUSION

There was consensus among the stakeholders in midwifery practice regarding the importance of providing proper orientation periods in professional practice, along with incremental increases in tasks and responsibilities. One way to improve working conditions for practising NQMs is to change the employment contracts for NQMs by a collaboration between the professional organisation of midwives and the responsible managers and practice owners in the regional collaborations. This study also shows that stakeholders agree on the need to provide trained mentors to support NQMs through mentoring and/or group coaching. Policymaking with a focus on supporting NQMs in their transition into practice might enable midwifery in the Netherlands to help NQMs provide the requisite quality of midwifery care.

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APPENDIX I Stakeholder analysis

Stakeholders	Primair	Secundair
Internal stakeholder	Manager labor ward Practice manager Newly qualified midwives Obstetricians Community midwives Hospital midwives	Student midwifery Coordinator internships Royal Dutch Organization of Midwives (RDM) - policy maker
External stakeholder	RDM board Midwifery Academies	Clients/patients Other collaboratives
Interface stakeholder	Insurance companies	Government-ministry of health

Stakeholders	Importance	Influence
Employers		
Manager labor ward Practice manager	High	High
Midwives primary care		
Practice owner	High	High
Fellow midwives	High	Low
NQMs Dutch/Belgium	High	Medium
Student midwives	High	Low
Midwives secondary care		
NQMs Dutch/Belgium	High	Medium
Hospital-based midwives	Medium	High
Supervisors		
Obstetricians	Medium	Medium
Multidisciplinairy team		
Obstetric nurses	Medium	Low
Maternity assistant	Medium	Low
General Practitioners	Low	Low
Pediatrician	Low	Low
External stakeholders		
RDM	High	Medium
Board of directors Midwifery academies	Medium	Medium
Academy of midwifery	Medium	Low

1. What do stakeholders need to know?

Primary stakeholders: outcomes of previous studies on NQMs.

Secondary stakeholders: knowledge about this study and the importance of the study.

Interface stakeholders: inform them about progress/outcomes.

2. What should stakeholders think?

Primary stakeholders: The employment position of NQMs needs to improve, interventions are needed in the organizational sphere and on the labour market position.

Secondary stakeholders: That they should contribute to realising the conditions.

Interface stakeholders: That they are aware of the developments on the labour market regarding NQMs.

3. What should stakeholders do?

Primary stakeholders: participate in the project, involve constituencies in this research.

Secondary stakeholders: be informed by the participants, take proposals seriously.

Interface stakeholders: read along, possibly provide resources.

4. What is the role of the target group?

Primary stakeholders: contribute directly, cooperate

Secondary stakeholders: monitor progress, contribute to realising preconditions.

Interface stakeholders: monitor the process and be informed.

5. What interest does the target group have?

Primary stakeholders: high/very high

Secondary stakeholders: moderate

Interface stakeholders: low

6. What does the target group think of the change?

Primary stakeholders: see the importance of welfare of starting midwives for continuity of midwifery care

Secondary stakeholders: are probably not that concerned with this change.

Interface stakeholders: probably not concerned with this changes.

7. What motivations play a role?

Primary stakeholders: replacement in practice, sufficient available colleagues/staff, continuity of care.

Secondary stakeholders: good connection education/ labour market, enough midwives, as few premature dropouts as possible.

DETERMINING INFLUENCING FACTORS

What impeding factors (obstacles) do we foresee at this point of improvement? Which factors are going to make it difficult for us to implement the change?

1. Educational structure HBO: dual/full-time
2. Organization of midwifery care
3. Observer position / self-employment / temporary contracts
4. Lack of culture/ tradition of mentoring/coaching of NQMs

What promoting factors (opportunities) do we see in this area of improvement. What will help us implement this change(s)?

1. Insufficient number of midwives available for observation/vacancies
2. Urgency of retaining entry-level midwives for the labour market has increased
3. RDM and profession is aware of urgency.

APPENDIX II Starting midwives in Dutch professional practice

Labour market context

More than three quarters of graduated obstetricians are working in primary care when they start practising, 72% of them as observers.[1] In practice, it appears that starting midwives mainly work as observers (ZZP-er), usually at several practices.

Well-being of NQMs

Starting midwives are more inspired than experienced midwives in the Netherlands, according to our own research. Emotional exhaustion and burnout symptoms score at similar levels (9% with burnout symptoms, 20% suffer from emotional exhaustion). (Kool et al, submitted). If learning opportunities, career prospects and available feedback are available, these are determinants of engagement, in addition to variation in work and autonomy. Contrary to international research findings, young and less experienced midwives in the Netherlands are not more susceptible to burnout symptoms.[2] This difference can possibly be explained by the work context. Starting midwives in the Netherlands are much more likely to work in primary care in contrast to abroad.

Job demands

The expectations of starting midwives in primary care and the reality in practice differ.[3] In practice, starters appear to work in different practices, often also in different regions. Being a self-employed midwife is not a choice for all starting midwives. At work, they have to get used to irregular shifts, making sure there are enough working hours and the amount of availability. They also lack routine in the work and regularly have doubts about the policy pursued.[1,3] The induction programme is lacking or consists of a verbal handover and written practical information. Direct colleagues are an important resource, although not available or present in the practice. Starting midwives use support from peers, who appear to be approachable and accessible. Starting midwives desire 24/7 backup from peers to test themselves when it comes to decisions they have made and build self-confidence as midwives. In addition, they desire regular collaboration with midwives. Midwives recognise the desire of starting colleagues but see their role as clients as a barrier and expect facilitation by other parties for this.

Starting midwives in the clinical setting still need further training in new tasks as midwives: managing additional midwifery skills several delivery rooms simultaneously and gaining a place in the team.[4] Temporary or 0-hour contracts make them feel like temporary or contingent team members. It seems common in the clinical setting for an entry-level midwife to be inducted before being allowed to function independently. In practice, the duration and content of the induction programme appears to depend on availability of clinical midwives. Starting midwives are eager to work with other midwives on a regular basis to achieve ongoing socialisation as a midwife. They also expect to be guided and supported by the gynaecologist and manager of the department in picking up their new tasks and responsibilities and to be able to fall back on them when necessary.

Core issues among starting midwives in the Netherlands

- Temporary increase in uncertainty and doubt about own functioning [3-6]

- Acquiring a place in the team [3-6]

- Learning to delegate to other disciplines [4]

- Asking adequately for help versus proving own competence [3,4]

- Lack of understanding and experience of practice organisation / larger team [3,4]

- Risk of dropping out / illness / leaving the profession early [1]

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APPENDIX III Findings round 1 Delphi Study

Of the 61 participants who agreed to participate in this Delphi study, 56 eventually completed it in full (91.8%).

For each statement, we calculated whether there was consensus on the importance and feasibility. We have reported this for each statement below.

If the text box per statement is green, consensus was reached. The results then go to the final results. If the text box is blue, then there is still no consensus or the comments add something so that the proposition is qualified and included in round 2. If the text box of the proposition is red, then the proposition was not considered important and the proposition from round 1 was rejected. For that, a new proposition is included in round 2.

Statements
1. Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract (e.g. temporary contract or locum).
Participants agreed on the importance of familiarisation. There is consensus on that. In contrast, in the comments, several participants made exceptions for front-line observers in terms of feasibility. They see obstacles to implementation there: because of funding (financial) and the independent position expected of a locum. Conclusion: nuance statement: Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract. If the midwife is a locum or is self-employed, their time spent on this must be compensated.
2. Every workplace should provide newly qualified midwives with clarity on tasks and responsibilities.
Applicable was supplemented in the comments by the importance of making or having manuals and scripts available in practice. Conclusion: Consensus reached, to results
3. A newly qualified midwife must be treated as a full team member because this contributes to their involvement in the workplace and to their self-confidence.
Comments provide nuance to the statement. People see starters as full team members, but not equal because there is difference in tasks and responsibilities. Conclusion: consensus,
4. To create a stable work environment, every newly qualified midwife should work in a salaried job at a workplace for their first year.
Importance of this is low in participants' results. Comments show diversity. Wage employment for all starters offers development opportunities in a workplace and stability on the one hand. On the other hand, it also limits development opportunities by being so fixed. Feasibility is scored low, because of the risk to the practice (financial)1 and freedom of choice of workplace for the starter. Conclusion: statement rejected, new proposition

Newly qualified midwives work better in a stable work environment, and so they should only be deployed for locum periods longer than three months in their first year after graduating
5. Each newly qualified midwife should only work in one VSV (verloskundig samenwerkingsverband) regional maternity care partnerships) in their first year after graduating.
No consensus on the importance of this proposition. People do see sufficient implementation of this proposition. Desirability is qualified, as it limits choice for the starter. Feasibility is not always possible because several ESLs are active in a city, for example. Conclusion: statement nuanced. Newly qualified midwives should preferably work within a VSV in their first year so that they work with stable collaboration partners and with only one set of protocols/agreements
6. In the first year after newly qualified midwives graduate, they should have a fellow midwife colleague who is available for consultation and/or backup.
Consensus reached on importance and feasibility. Comments indicate that the employer is responsible for payment. Some see the first year mainly as work experience. More education and training reduces the possibility of gaining work experience. Others see the importance of mentoring and training because it helps the starter work in practice. Conclusion: Consensus reached, discrepancies in remarks: nuancing statement: Within a VSV, a backup staff member/colleague is always available to newly qualified midwives during their first year after graduating for consultation and/or to act as a sparring partner
7. Newly qualified midwives regularly get feedback on their performance from a partner/manager.
The results show consensus on importance and feasibility. People mostly see being able to call a rear guard as standard procedure for all midwives, regardless of the amount of work experience. Only among the comments are some nuances, such as too long a period of a rear guard, and the burden on incumbent midwives. 1 Conclusion: consensus reached. .
8. In the first year after newly qualified midwives graduate, they receive facilities (for training/coaching) to fully master their profession.
Consensus reached on importance and feasibility. Comments suggested that tailor-made guidance should be possible and that the one-year duration is difficult to implement organisationally. It was also noted that it is important to link up with existing forms of consultation in practice. Conclusion: consensus reached on importance, feasibility.
9. In the first year after a newly qualified midwife graduates, they must take part in a transition programme to get a good feel for the field..
Many comments that this should be common practice for all midwives, not just starters. Conclusion: consensus not reached. New statement: Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).
10. In the first year after newly qualified midwives graduate, they have a mentor at their workplace whom they can consult about all sorts of work situations.
The results show that there is no consensus on importance and feasibility. People think a programme is not necessary because it interferes with the freedom of choice of starting midwives. Other arguments are that it is too intensive and interferes with gaining work experience in practice.

Conclusion: no consensus, proposition rejected. New proposition: In the first year after newly qualified midwives graduate, they are entitled to guidance (through supervision, a mentor, a buddy, or another form of guidance) to be able to spar about all sorts of work situations.
11. During newly qualified midwives' first year in practice, they all have a guiding peer support group to ensure that they will continue to learn and develop.
The comments show that this is potentially important for all midwives and is also the starter's own responsibility. Conclusion: consensus reached, towards results
12. Newly qualified midwives all have a mentor outside their own workplace, who can support, coach, and advise them in work matters
Comments: On usefulness and necessity of mentoring separate from the workplace, there are conflicting responses, such as important for personal development to not needed, unnecessary luxury. Conclusion: no consensus on importance, nuance statement: If desired, newly qualified midwives should have access to a mentor outside their own workplace, with whom they can discuss work matters.
13. Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).
Comments: importance of facilities for this and that for the incumbent profession this is simply part of a midwife's remit. Conclusion: consensus on importance and feasibility, by results
14.The university of applied sciences (HBO) Bachelor's programme in midwifery is responsible for well preparing all VIOs (verloskundigen in opleiding; midwives in training) for them to start as professionals in birth care.
Comments are about responsibility of the placement practice to prepare students for practice and that not all tasks are already visible during training, such as being self-employed and being a partnership member. This needs to be experienced in practice. Shared responsibility between training and practice. Conclusion: consensus reached, towards results
15 The university of applied sciences (HBO) Bachelor's programme in midwifery is partly responsible for guiding newly qualified midwives in their first year after graduation..
Comments on responsibility of the field for mentoring start-up professionals and lack of existing facilities and their desirability for every start-up. Conclusion: no consensus on importance and feasibility, so rejected. New statement: The profession field of midwives is responsible for guiding newly qualified midwives in their first year after graduation.
16. The second half of the university of applied sciences (HBO) Bachelor's programme in midwifery is offered in dual form, whereby the student partly follows an educational programme and partly works as a midwife in training (VIO, verloskundige in opleiding).
Comments on feasibility (financial and organisational) but also on its importance. People see four years of training as sufficient to prepare for the profession. Conclusion: consensus just not reached, nuancing statement: In the last two years of the university of applied sciences (HBO) Bachelor's programme in midwifery, the emphasis lies more on gaining practical experience than on theoretical education

Key statements:

1. Introduction in practice
5. Working within one collaboration in one region
6. Facilitation of training

Least important statements:

4. Employment for all locums
5. Working within one collaboration partnership in one region
6. Facilitate training

Conclusion: Introduction and settling in is the most important statement. Pronounced division on propositions 5 and 6.

CHAPTER 8

General discussion

The aim of this thesis is to contribute to the knowledge about NQMs' experiences when transitioning-into-practice, NQMs' and experienced midwives' occupational wellbeing, and to gain insight into how to support NQMs' transition-into-practice. Furthermore, we conducted a study on the wellbeing of experienced midwives and the determinants of that wellbeing, and on the decision-making processes of midwives with intentions to leave the profession. Finally, we explore experienced midwives' perceptions regarding NQMs, and their role in and contribution to supporting NQMs' transition-into-practice.

MAIN FINDINGS

The first research question concerns the experiences of NQMs during their transition-into practice in two work environments: the community and the hospital.

How do NQMs perceive their transition-into-midwifery practice and how is this transition supported in practice?

NQMs' perceptions

In the context of community-based midwifery, the findings show that NQMs perceived the transition-into-practice as both liberating and difficult. NQMs perceived themselves as liberated after graduation, after which they work without supervision of a midwife. On the other hand, the transition was difficult because of the decision-making responsibilities and the differences between their expectations and the reality of practice. In NQMs' perceptions, the administrative and organizational aspects of the as well as working as a locum midwife in various practices and regions, was demanding. Working without routines in practice costs them a lot of their mental capacity, time, and effort. Job resources included support from colleagues, when available, and peers. However, interaction with colleagues could also be experienced as a job demand if they were the practice owners, since they regularly acted as commissioners, which made NQMs feel dependent on them for future work. Support for NQMs in the practice organization is mostly informally organized, with the introduction consisting of a preliminary interview and a practice folder containing information on practical matters. Support from peers seemed important for NQMs, and was available in practice. They contacted their peers frequently, and perceived their support as 'safe'.

Hospital-based NQMs perceived the transition-into-practice differently than community-based NQMs. They experienced the hospital environment as demanding: the job came with a high workload, with the expectation that they could manage several birthing suites simultaneously, and they were required to start working both as a team member and while being supervised by an obstetrician. Working within a

multidisciplinary team and the variation in the work with pregnant women in the hospital were perceived by NQMs as helpful in this transition. There was usually an introduction period, during which tasks and responsibilities were expanded. The multidisciplinary teams in hospital settings also felt responsible for the quality of NQMs' work in practice. After settling in, support for NQMs remained informal. Peer support was less important for hospital-based NQMs, because most peers did work in the community.

In both work environments – the community and the hospital – job insecurity obstructed NQMs in their work in a team. They felt like temporary team members. Although fellow midwives were valued as important role models and as equal sparring partners, the possibilities for working alongside fellow midwives in practice were scarce.

Established midwives perceived NQMs as having problems adapting to their new role and responsibilities in practice and working autonomously. They experienced NQMs as focused on their own tasks and shifts, and as protective of their time off. They therefore perceived NQMs as less committed to the practice and to organizational tasks compared to their own start in their jobs. On the other hand, established midwives were aware of NQMs' need to continuously learn and develop as professionals. Regarding support for NQMs, different opinions were given. Some practice holders said that putting effort into training of NQMs ultimately leads to better colleagues, and can thus guarantee the quality of care provided in their practice. Others did not see this opportunity to support NQMs, because they felt they were commissioners and not employers of locum-working NQMs.

Midwives' wellbeing and its determinants

The second research question in this thesis was about the occupational wellbeing of midwives:

What are the levels of wellbeing of NQMs and experienced midwives in the Netherlands, and which determinants are associated with wellbeing and intentions to leave the practice?

The population of practicing midwives in this study consisted of 896 midwives, a quarter of the total population of midwives in the Netherlands. In this sample, based on measurement through self-assessment scales, seven percent of the midwives were found to have burnout symptoms. One in five midwives suffered from emotional exhaustion at work. All measured job demands (changing tasks, complexity, emotional load, mental load, organization of work, physical strain, problems with tasks, variety, work pace and work quantity) were found to be burnout symptoms. The number of years of work experience was not a determinant of burnout. Regarding midwives' positive wellbeing, midwives scored high on work engagement: 40% of the respondents were highly

engaged in their work. NQMs showed higher rates of work engagement compared to experienced midwives. Therefore, the years of work experience appears to be a determinant of work engagement. Job resources associated with work engagement were: autonomy, career opportunities, clear responsibilities, collaboration with colleagues, communication, contact opportunities, feedback, financial rewards, job security, learning resources, variety, and work and rest times. Personal resources were more strongly associated with work engagement than job resources. All four measured personal resources, hope, resilience, optimism, and self-efficacy, were important determinants of work engagement.

The quantitative findings of the study on intentions to leave the practice among Dutch Community-based midwives show that almost a third of the population planned to leave the profession within a year. A variety of factors were found to contribute to intentions to leave the job. Family commitments, in combination with heavy workloads and responsibilities as a practice owner, were perceived as a heavy burden in their job. Our findings also revealed that one third of the population of midwives was not satisfied with the organization of the practice. The qualitative part of this study demonstrates that the final decision to stop practicing midwifery turned out to be a process over time, during which midwives tried to improve their working conditions (job crafting). If they failed to do so, they became frustrated and felt a loss of commitment to their work, which also affected their performance in practice. The accumulation of job demands that they were no longer able or willing to meet, combined with poor social support from colleagues and responsibilities to their own families, ultimately led to the decision to quit.

Support for NQMs

The third research question concerned the support given to NQMs in their transition-into-practice.

What are the desired and the feasible components of support for the NQMs' transition-into-practice?

Desired components of support, according to stakeholders' opinions, are an introduction period, 24/7 support for NQMs, adequate feedback on performance, and aligning roles and responsibilities. Furthermore, stakeholders expressed that every NQM should be mentored or coached by trained mentors and coaches during their first year in practice. Financial and organizational issues emerged to bar the feasibility of these components, however. Introduction in practice and 24/7 back-up for NQMs in practice seemed important, but was sometimes not feasible due to the workload of experienced midwives. Regional arrangements between practices were important to provide the necessary

support. Facilitating coaching, mentoring or group counselling for NQMs seemed to be feasible according to stakeholders, either within or outside the workplace. They felt that being able to give NQMs the choice between mentoring or coaching, based on NQMs' special needs, is important. However, a stable working environment for NQMs in practice, which emerged as very important in international research, appeared to have a lower priority in stakeholders' opinions.

DISCUSSION OF THE MAIN FINDINGS

In this section, we reflect on the main findings of this thesis. We first reflect on the transition-into-practice of NQMs, then on the occupational wellbeing of midwives, and finally on the transition support for NQMs.

Transition-into-practice

As written in the introduction of this thesis, transition into practice entails 'a foundational period, whereby a newly registered practitioner can build competence and confidence as an autonomously working professional'.[1] We reflect on NQMs' perceptions of their transition-into-practice, and their need for support during this transition. We also reflect on stakeholders' views of the working conditions for NQMs and the autonomy of NQMs in practice.

According to our findings, NQMs and established midwives recognize a transition period in which NQMs need to learn to work across the full range of midwifery practice (Chapter 2,3 6). This includes performing administrative and organizational tasks, taking full responsibility for the care of pregnant women, and becoming a trusted team member in local and regional maternity care collaborations. Dutch NQMs noticed that they felt less competent and less confident in their decision-making, which is consistent with experiences reported in previous research (Chapter 2,3).[2-5] These findings are also similar to research findings about young doctors' readiness to work in independent practices.[6] Both NQMs and young doctors felt less competent in management, administration, and leadership tasks.[6,7] This may be explained by the level of competence at the time of graduation.[8] NQMs are qualified to provide care to pregnant women as competent professionals, but they perform as beginning competent professionals in organizational and managerial tasks.[9] They have to develop themselves from beginning competent professionals, whose behaviour is based on context-free rules, to fully competent professionals, whose behaviour is based on situational rules in the specific context.[8]

Building expertise requires deliberate practice with performance in practice guided by mentors or coaches.[10] However, the current quality of learning and development of NQMs depends on the quality of NQMs' self-directed and self-regulated learning skills,

which hinders effective socialization in practice (Chapter 2,3,5).[11,12] For NQMs, the development process during the transition-into-practice period is based on random work experiences without individualized and formalized support or guidance from midwives as role models and mentors.[13,14] Although we did not measure the performance of NQMs, research suggests that, without adequate support, the quality of care provided by NQMs for their clients may not meet the required standard.[1,15] The level of competence of NQMs in client-centred tasks appears to be high immediately after graduation appeared to be high, but it is possible that a heavy workload and new roles and responsibilities may lead to uncertainty and unnecessary referrals to secondary care.[16] The opportunity to review and discuss cases with fellow midwives is important in preventing this drop in quality.[16,17]

The lack of recognition from stakeholders for the need for NQMs to work in a stable work environment surprised us (Chapter 7). Stakeholders in midwifery recognized the need for NQMs to develop their competences in practice. At the same time, they underestimated the importance for NQMs to work in a stable work environment, close to fellow midwives. Organizational barriers may explain this lack of recognition. The current system of midwifery care in the Netherlands, with locum-working, self-employed NQMs,[18] makes it virtually impossible for practice owners and managers to act as a responsible employer towards NQMs. According to labour legislation, practice owners are not allowed to act as employers towards locum midwives.[19] They can only act as commissioners.

Our findings show that the lack of collaboration with an experienced midwife, the lack of support from available midwifery colleagues, and working in temporary employment are highly demanding for NQMs (Chapters 2, 3). The percentage of exhaustion among NQMs is relatively high at 16%, meaning that a large number of NQMs are at risk of developing burnout symptoms.[20] Providing NQMs with a stable work environment enables them to build solid relationships with clients and colleagues,[5,21] provides them with opportunities to familiarize themselves with running a practice organization, and allows them to further develop the required level of competence under the guidance of experienced midwives (Chapter 7).[13,14]

According to our findings, emotionally rewarding job resources for NQMs are working "with women" and autonomy at work (Chapter 2,3,4). These findings appear similar to previous research on midwives' wellbeing.[22] The importance of these resources for Dutch NQMs needs to be recognized in midwifery practice. Dutch NQMs currently have to work in a changing organizational maternity care landscape.[23] Regional protocols and

agreements in collaboration with other maternity care professionals are becoming mandatory in an increasing number of work environments. The autonomy of midwives may be compromised by these changes in the organization in midwifery care.

Occupational wellbeing

We first reflect on the wellbeing of Dutch midwives as compared to the wellbeing among midwives internationally, and then on the differences in wellbeing between NQMs and experienced midwives.

According to our findings, the occupational wellbeing of midwives in the Netherlands is high compared to the wellbeing among midwives internationally.[21] Dutch midwives show low incidence of burnout symptoms and a high degree of work engagement (Chapter 4). Although these findings are cause for optimism, we also have some concerns. Namely, the combination of high exhaustion and high work engagement among Dutch midwives, which puts them at risk of developing burnout symptoms and poor performance.[20] Dedicated professionals may become exhausted, because they may deplete their mental and cognitive resources when they are actively engaged in their work.[20]

Our findings suggest that midwives in the Netherlands display a lower percentage of burnout symptoms (7%) compared to their colleagues in other countries (20 to 60%) (Chapter 4). Available job resources for Dutch midwives such as autonomy and working with pregnant women may explain this low percentage of burnout symptoms.[24-26]

Our findings contribute to the existing literature on midwives' wellbeing and its determinants. We were the first to include the measurement of work engagement in a large sample of midwives. We also measured personal resources as a determinant of midwives' wellbeing. The important role of personal resources on midwives' wellbeing appeared of similar importance in other health professions.[27-29] Similar associations were found between personal resources, such as hope, optimism, resilience and self-efficacy, and work engagement, and between personal resources and lower incidence of burnout symptoms (Chapter 4). Our findings concerning the associations between personal resources and wellbeing may suggest that Dutch midwives rely mainly on their personal resources in their work.

Regarding NQMs' wellbeing, our findings show a high degree of work engagement and low incidence of burnout symptoms among NQMs (Chapter 4). NQMs are significantly more engaged than established midwives. Burnout symptoms and levels of exhaustion do not differ between the two groups. These findings were surprising, because previous findings on newly qualified health professionals (NQPs) suggest the opposite.[21,30,31] Being young and having little work experience contribute to burnout symptoms and to

lower work engagement in NQPs. An explanation for these findings may be the work environment of NQMs in the Netherlands. NQMs mainly work in community practices,[2] where their work with pregnant women is often aligned with their own midwifery values and ideology.[32] Previous findings on Dutch student midwives show the importance of 'enhancing physiology' in pregnancy and childbirth in becoming a good midwife.[33] Job resources such as autonomy at work and working 'with pregnant women' seem to contribute positively to Dutch NQMs' wellbeing at work.

Both NQMs and experienced midwives in the Netherlands are highly engaged in their work (Chapter 4). Our findings on midwives are encouraging, as it is known that working with people in social and health care contributes to positive wellbeing.[30] Internationally, our findings provide a basis for measuring midwives' work engagement, as an international comparison of midwives' work engagement is not yet available.[34] By including work engagement and its determinants, international research on midwives becomes more comprehensive.

Transition support

Similar to international conclusions, our findings show that NQMs need support in practice after graduation (Chapters 2,3,6,7).[5,35,36] Research suggests that support for NQMs is effective for their wellbeing, but also beneficial for the quality of care they provide.[37-40] In our studies, NQMs' need for support from fellow midwives was recognized by all stakeholders (Chapter 6,7). However, in current practice, support from fellow midwives for NQMs is not formally arranged and available, and is mainly dependent on the goodwill of fellow midwives. Midwives expect NQMs to be able to work as an independent (locum) midwife, which requires a level of competence they do not yet have when they enter practice (Chapter 6). These findings reveal discrepancies between established midwives' attitudes and behaviour towards supporting NQMs. Midwives believe that NQMs learn and develop through serendipitous practice experiences rather than through deliberate practice experiences with their colleagues.[10] The discrepancy between midwives' beliefs and behaviour may be found in the reasoned action perspective.[41] This perspective suggests that attitudes and behaviour are usually activated by automatic processes. Moreover, attitudes can vary depending on the context in which they are expressed or based on inadequate information or beliefs. From this perspective, established midwives believed that NQMs primarily learn from random practice experiences. They also believed that NQMs need to develop competences in practice. In their attitude they recognized NQMs' need for development. In their behaviour, however, they felt themselves conditionally able to support NQMs.

Established midwives were willing to support NQMS if facilitated. They also believed that practice owners cannot act as employers. In their behaviour, they prioritized client care and practice organization over supporting NQMs. So, we expected midwives to act in accordance with their positive attitude towards supporting NQMs, but they behaved differently. Another explanation for the discrepancy between midwives' attitudes and behaviour in supporting NQMs could be found in the JD-R model. This explanation is connected to the high level of exhaustion among Dutch midwives.[42] Exhausted midwives lack the energy for performing tasks outside their assigned role, which is sometimes required to support the smooth functioning of the organization.[42,43] They focus on in-role performance through carrying out tasks for which they are directly responsible. Caring for pregnant women and maintaining the organization of the practice are their priority, and they may cope with exhaustion by underperforming in other roles, such as supporting new colleagues.[42]

Established midwives perceived NQMs as lacking commitment to their practice organization, and as prioritizing their time away from work over being available for practice (Chapter 6). Our findings on NQMs' work engagement (Chapter 4) suggest the opposite. NQMs were highly engaged in their work, as shown in Chapter 4. There are several explanations for these differences in perceptions of NQMs in practice. Firstly, generational differences in the prioritization of work and private life could help explain the differences in work attitudes.[44,45] Differences in opinion between generations regarding the balance between work and private life exist, and challenge intergenerational teams to deal with these differences.[44,45] Dutch midwives expected NQMs to fit into the current practice organization as they did themselves when they entered practice (Chapter 6). They felt themselves to be more committed to their jobs than they perceived NQMs to be. Although they struggled to let go of their work during their time off (Chapters 2, 3), NQMs tried to balance their professional and private lives, . They did so by setting boundaries, which was experienced by established midwives as reduced commitment to their jobs. Secondly, NQMs have weaker links to their workplaces and teams due to locum or temporary employment contracts (Chapters 2,3). It is known that commitment to an organization depends on the quality of the socialization within an organization.[46] Temporary or locum employment, combined with a lack of support in the practice, may play a role in the attitudes and behaviour of NQMs. When established midwives began their transition into practice, their situation was different from that of NQMs today. They often started as a new partner in a practice organization, and their final internships often happened in the practice where they would have their first jobs, which meant that they had their induction period before graduation, and were already familiar with the practice during their transition period. (Chapter 6).

Finally, NQMs are unaware of their roles and responsibilities in the practice organization, which in turn may be due to a lack of competence in organizational and administrative tasks (Chapters 2,3).[6] Even though these competences could be further developed during their educational programme, without explicit socialization into a practice organization, NQMs will continue to have difficulties understanding what is expected from them as responsible practice team members.

In summary, the findings of this thesis suggest differences in midwives' attitudes and behaviour towards the socialization and support of NQMs in practice, towards the learning and development needs of NQMs in practice, towards the expected levels of organizational and managerial competence of NQMs, and towards responsibility for the organization of the practice (Chapters 2,3, 6,7). This thesis also identified differences in perceptions about NQMs' level of competence during their period of transition-into-practice (Chapters 4, 6,7) and in attitudes to work and home life (Chapters 2,3,6). Established midwives valued working in practice, and valued employability and availability for the job, as suggested by the study of intentions to leave the profession (Chapter 5).[47] Participants – midwives who had left their job as a midwife – considered themselves a burden to their colleagues when faced with physical or psychological limitations. Building a sustainable midwifery workforce requires recognizing and valuing differences in midwives' competences, attitudes, and abilities, and valuing these differences in the organization of midwifery care. Recommendations for building sustainability in the workforce are provided in the Implications section.

METHODOLOGICAL CONSIDERATIONS

Strengths and limitations

One of the strengths of this thesis, as compared to other international studies on midwives' wellbeing, is that we accounted for the dimension of positive wellbeing. By including the motivational process in the study of midwives' wellbeing, we obtained a more complete understanding of wellbeing. The existing knowledge on midwives' occupational wellbeing was focused on burnout and its determinants. Furthermore, we have shown the importance of personal resources as determinants of wellbeing: they serve as a buffer when it comes to burnout symptoms, and they enhance work engagement.[48,49]

Another strength of this thesis is that NQMs' transition-into-practice was studied comprehensively. Different perspectives on this topic were studied by involving various stakeholders (NQMs, established midwives, managers, practice owners), and by looking

at a variety of perspectives (work environment, occupational wellbeing, and transition support). Moreover, a variety of methods were used. The consecutive steps in the qualitative and quantitative studies provided opportunities to enrich the data collection and data analysis over the next steps.

All studies were conducted by a multidisciplinary research team with experienced researchers in different fields: general and veterinary medicine, midwifery, and educational and psychological sciences, which has made this study more robust. The different perspectives on research on healthcare professions and the scope of primary care have contributed to the quality of all studies in this thesis.

Our studies also have limitations. Exploratory research was conducted, as there was little existing research on midwives in the maternity care context of the Netherlands. We could only establish associations, which are more limited connections than causal relationships. Another limitation of this thesis was the small population of NQMs in the Netherlands. We were therefore limited in our multivariable statistical analysis of the determinants of wellbeing. Another limitation is the generalizability of our findings. Although we included a quarter of the population of midwives in the Netherlands, the generalizability for hospital-based midwives is limited, due to the limited number of hospital-based midwives in our sample. Furthermore, by focusing on midwives within one country, we might have limited the international generalizability of our findings. For instance, the work environment of NQMs and experienced midwives in the Netherlands differs from the work environment of midwives in other countries, as they work mainly in hospitals. However, our study does contribute to the existing knowledge of community-based NQMs. Our findings may provide tentative indications for the wellbeing and transition-into-practice of NQMs and midwives in midwifery-led settings in other countries.

Both a strength and a limitation of our studies is the choice for the burnout measurement scale, the Utrecht Burnout Scale. Using this scale, we were able to compare our findings with several national and European findings on occupational wellbeing. However, as a result of this choice, the Burnout Scale differs from the one used in most global studies of midwives' wellbeing.[21] Other studies on midwives' wellbeing internationally mainly used a different measurement instrument: the Copenhagen Burnout Inventory.

IMPLICATIONS

For midwifery organizations

This thesis has cast light on the current level of occupational wellbeing of NQMs and experienced midwives, and what is needed and important to improve the wellbeing of midwives. According to organizational change theory, knowledge and understanding of the wellbeing of NQMs are a first step towards changes in the transition of NQMs into practice.[50] Our findings in this thesis suggest systemic changes to help NQMs integrate into the midwifery workforce.

Regarding the transition of NQMs into practice, we have established stakeholder agreement (Chapter 7) on a shared vision, on commitment to socialization into practice, and on the required components of support for NQMs in practice. The next step is developing a shared vision on how to organize and manage the necessary changes in practice.[50] Maternity care organizations, i.e. midwifery practices, hospitals, and regional corporations or collaboratives, need to take responsibility for implementation. They can do so by identifying leaders who can become responsible for arranging these components of support for NQMs at the local or regional level.[50]

For the wellbeing of NQMs and the quality of their performance in practice, it is recommended that everyone concerned should be involved in implementing the following components of support: formal induction into practice, 24/7 support from colleagues, performance feedback from practice owners or managers, and mentoring from fellow midwives. Furthermore, it is recommended to change the temporary employment conditions for NQMs in their first year in practice to a stable environment to guarantee a safe start in practice and quality of performance for all NQMs. Under these conditions, NQMs will be able to work in practice with available colleagues, which in turn will allow them to learn more deliberately from practice experiences and develop into fully competent midwives. For the community, the rationale for this recommendation is that the self-employed status of NQMs, which requires them to work as locum midwives, has hindered their induction and socialization in practice (Chapters 2, 6, 7). Therefore, a reassessment of the labour requirements for locum midwives is recommended. In hospitals, we found a similar situation for NQMs who work on a zero-hours contract. This makes them a temporary team member, and less committed to the organization.

At a local level, we believe *managers and practice owners* need to take the lead in working with established midwives and other colleagues to implement support for NQMs. In the community, it is recommended that permanent employment contracts be provided to

NQMs instead of locum work in the community. Local and regional collaborations need to be established to support first-year employment contracts and support for all NQMs. In the hospitals, similar leadership is needed to provide support and more stable working conditions for all NQMs during their first year in practice

Experienced midwives need to act on their beliefs regarding NQMs in practice. Midwives are crucial actors during the transition of NQMs into practice, both as role models, and in stimulating the development of midwifery expertise. It is recommended that midwives are made aware of the discrepancies between their attitudes and beliefs about NQMs in both communities and hospitals.

For midwifery education

Midwifery academies in the Netherlands are recommended to include both the socialization of students as members of a specific profession and the subjectification of their students as responsible, reflective, and independent professionals in their curricula.[51] Midwifery curricula could focus more on students' personal resources early in the programme and develop, train, or optimize these personal resources towards resilience, hope, optimism and self-efficacy.[52] In developing personal resources, it is recommended that attention is also paid to students' personal demands, such as setting boundaries and perfectionism, and to stimulate students to efficiently manage these personal demands. Recent research suggests that personal demands play an important part in the effectiveness of the development of personal resources.[53,54] In addition, support and guidance in the development of personal resources may help student midwives to be more effective learners during their internships, which may help to make the transition-into-practice easier.[53]

It is also recommended that midwifery academies train their students in competences required to work in a community or in a hospital. For work in communities, this means learning to work with different clients in maternity care teams in a shift, as well as organizational and administrative tasks.[13] For the hospital setting, it means learning additional midwifery skills, learning to work as a member of a multidisciplinary team, and learning to work partly autonomously with women in low-risk situations and partly under the supervision of an obstetrician with women in medium- and high-risk situations.[14] Our findings show that NQMs felt ill-prepared to work in these specific work environments.

With the introduction of the master's degree in midwifery in 2023 in the Netherlands, it is recommended that a division of competences for midwives at bachelor or master level be made. For example, basic organizational and collaborative tasks are required at bachelor level for the care of women and for tasks related to the organization of one

practice. Leadership and organizational skills at master level include working as a midwife in collaborations at regional or national level. In addition, leadership, entrepreneurship, mentoring, and coaching should be developed by midwives at master's level.

For future research

For future midwifery research, we recommend three different approaches to studying NQMs' wellbeing. Firstly, design-based research is recommended to design the various required components of support for NQMs based on literature and previous research outcomes. Effective components of support can be designed for NQMs in specific work environments – the hospital and the community – and can be used as a blueprint for implementation of support at a regional level. Secondly, participatory action research is recommended, focusing on the implementation of components of support for NQMs during the transition-into-practice at the local or regional level. Both the design-based and the action research approach will enable researchers to better understand the implementation of these components, and how to prioritize, monitor, and improve these implementations. In addition, successful implementations could be replicated elsewhere, and facilitators and barriers could be identified on an international scale. Finally, research that explores and measures the effectiveness of different components of support, and their contribution to the wellbeing of NQMs and their performance in practice, is also recommended.

Across the whole midwifery profession, we recommend a longitudinal approach to gain insight into midwives' wellbeing over time, and whether there are fluctuations in midwives' wellbeing, and in their intentions to leave or to remain in the profession. With these data, trends in midwives' wellbeing over time, and at different stages of their careers, can help provide more causal insights into determinants, help monitor recommended changes, and, hopefully, ultimately help build a more sustainable midwifery workforce, and identify new opportunities for interventions where needed.

CONCLUSIONS

For NQMs, the transition-into-practice in maternity care in the Netherlands is a big step from being a student to being a registered and responsible midwife in community and hospital environments. The community and the hospital each have their own work-related challenges. In communities, NQMs mostly work as locum midwives, where they face the challenge of combining providing care with organizational and administrative tasks, mainly without the support of a fellow midwife. In hospitals, NQMs have to learn to manage several birthing suites, and to work partly autonomously and partly under the supervision of an obstetrician. NQMs need support from fellow midwives in both work

environments, but in practice, this support is not always available – at least not formally. Stakeholders are committed to the importance of support for NQMs, but established midwives do not yet act accordingly.

NQMs and experienced midwives in the Netherlands are highly engaged in their work in maternity care. NQMs are significantly more engaged than experienced midwives. Determinants of midwives' positive wellbeing are various factors, such as working with colleagues and 'with women', together with trainable personal resources, such as resilience and optimism. One in three midwives intend to leave the profession. Determinants of intentions to leave, and reasons for leaving the profession for community-based midwives are a combination of high workload, practice owner roles and responsibilities, and family responsibilities.

Components of support for NQMs as agreed by stakeholders include proper induction in practice, expansion of tasks and responsibilities with performance feedback from practice owners or managers, 24/7 back-up during a shift, and mentoring and coaching on work experiences. Systemic, organizational, and cultural aspects of midwifery care hinder the implementation of formal support.

We recommend establishing a transition period for all NQMs working in the Netherlands in their first year of practice. We recommend that this period is supported by stable employment combined with practice support. NQMs cannot work at the competence level required for a locum midwife. Components of support on which there is consensus among stakeholders can be implemented at local and regional level, where practice owners and managers should take responsibility for implementation. Design-based research is recommended to further develop detailed support components based on existing literature. At local or regional level, participatory action research can be used to implement these components in a specific region.

Regarding midwives' wellbeing, periodic measures of their wellbeing in practice, their intentions to leave the profession and their intentions to remain in the profession are recommended. Trends in midwives' wellbeing over time and at different stages of their careers, and on specific job demands and resources, may help identify opportunities for intervention and build or enhance a sustainable midwifery workforce.

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CHAPTER 9

Summary

This thesis deals with the occupational wellbeing of midwives in the Netherlands with a focus on newly qualified midwives (NQMs) and their transition into practice. We identified the job demands and resources as perceived by newly qualified midwives who work in the community or in the hospital (chapter 2 and 3). The next chapters focus on different stakeholders' perceptions regarding NQMs transition-into practice, the wellbeing of NQMs and experienced midwives and its' determinants and on midwives who (have intentions to) leave the profession and how this process works.

Chapter 1 concerns a general introduction to the subject, problem and objective of this thesis. Definitions and descriptions are provided of occupational wellbeing, transition-into-practice, and the specific training of midwives and the organization of midwifery care in the Netherlands. Furthermore, the Job Demands Resources model as theoretical framework is explained. This thesis aims to provide knowledge about 1) the occupational wellbeing of NQMs in practice, 2) the transition-into-practice experiences of NQMs, and 3) how to support this transition period in practice. As research shows that NQMs in practice need supportive fellow midwives for self-confidence and feelings of competence in practice, we also studied experienced midwives' wellbeing, their perceptions on supporting NQMs, and whether they have intentions of leaving the profession.

Research questions within this thesis are:

1. How do NQMs perceive their transition-into-midwifery practice, and how is this transition supported in practice?

2. What are the levels of wellbeing of NQMs and of experienced midwives in the Netherlands, and which determinants are associated with wellbeing and intentions to leave the practice?

3. What are the desired and the feasible components of support of the NQMs' transition-into-practice?

Chapter 2 concerns a qualitative study among community-based NQMs. The aim of this study is to identify perceived job demands and job resources of NQMs, working in primary midwifery care during their first years in practice. A qualitative study, with semi-structured group interviews was conducted. Midwives working less than three years in primary midwifery care in the Netherlands were invited to join a focus group interview. Five focus group interviews took place with 31 participants. Data were analyzed thematically by using the different characteristics of the Job Demands Resources model. Working as a locum midwife is demanding for Dutch NQMs, due to a large number of working hours in different practices and a lack of job security. Decision-making and

adapting to local guidelines and collaborations demand a high cognitive load. These aspects of the work context negatively impact NQMs' work and private life. Working with clients and working autonomously motivates the new graduates. Support from colleagues and peers are important job resources, although colleagues are also experienced as a job demand, due to their role as employer. Strictness in boundaries, flexibility and sense of perspective are NQMs' personal resources. On the other hand, NQMs perceived perfectionism and the urge to prove oneself are personal demands.

Dutch NQMs' first years in primary midwifery care are perceived as highly demanding. In primary care, NQMs usually work as locum midwives, self-employed and in different practices. Building adequate support systems might help NQMs finding a balance between work and private life through having experienced midwives available as mentors. Improving NQMs' working position requires secure employment conditions.

Chapter 3 studied the transition-into-practice experiences of NQMs who work in a hospital setting. In the Netherlands, a percentage of NQMs start work in maternity care as a hospital-based midwife, although they were prepared particularly for working autonomously in the community. This study aimed to explore Dutch NQMs' perceptions of their job demands and resources during their initiation to hospital-based practice. We conducted a qualitative study with semi structured interviews using the Job Demands-Resources model. Twenty-one NQMs were interviewed individually. Transcripts were analysed using thematic content analysis. High workload, becoming a team member, learning additional medical procedures and job insecurity were perceived demands. Participants experienced the variety of the work, the teamwork, social support, working with women, and employment conditions as job resources. Openness for new experiences, sociability, calmness and attention to detail were experienced as personal resources, and perfectionism, self-criticism, and fear of failure as personal demands. Initiation to hospital-based practice requires from NQMs adaptation to new tasks. Sociability helps NQMs in becoming a member of a multidisciplinary team; neuroticism and perfectionism hinders them in their work. Clear expectations and a settling-in period may help NQMs to adapt to practice. The initiation phase could be better supported by preparing student midwives for working in a hospital setting and helping manage expectations about the settling-in period.

Chapter 4 examined the occupational wellbeing of midwives in the Netherlands and its determinants. Internationally, about 40 percent of midwives report symptoms of burnout, with young and inexperienced midwives being most vulnerable. There is a lack of recent research on burnout among Dutch midwives. The aim of this study was to examine the occupational wellbeing and its determinants of newly qualified and

experienced midwives in the Netherlands. A cross-sectional study was conducted using an online questionnaire that consisted of validated scales measuring job demands, job and personal resources, burnout symptoms and work engagement. A total of N=896 midwives participated in this study, representing 28 percent of practising Dutch midwives. Data were analysed using regression analysis. Seven percent of Dutch midwives reported burnout symptoms and 19 percent scored high on exhaustion. Determinants of burnout were all measured job demands, except for experience level. Almost 40 percent of midwives showed high work engagement*;* newly qualified midwives had the highest odds of high work engagement. Master's or PhD-level qualifications and employment status were associated with high work engagement. All measured resources were associated with high work engagement. A relatively small percentage of Dutch midwives reported burnout symptoms, the work engagement of Dutch midwives was very high. However, a relatively large number reported symptoms of exhaustion, which is concerning because of the risk of increasing cynicism levels leading to burnout. In contrast to previous international research findings, being young and having less working experience was not related to burnout symptoms of Dutch NQMs.

Chapter 5 concerns a mixed-methods study, whereby midwives' intentions to leave and reasons to leave the job was explored. In the Netherlands, the turnover of midwives of relatively young age is high. This is concerning since a lack of experience in the workplace can negatively affect the quality of maternity care. This study aims to identify the rate and the reasons for intending to leave, and to explore the reasons for leaving midwifery jobs in the Netherlands. We used a mixed-methods design including a quantitative survey (N=726) followed by qualitative interviews (N=17) with community midwives. Almost one third of the respondents considered leaving the profession. The decision to actually leave the job was the result of a process in which midwives first tried to adapt to their working conditions, followed by feelings of frustration and finally feelings of decreased engagement with the work. Compared to international figures, we found a lower rate of midwives who considered leaving the profession. This could be explained by the differences in the organisation of midwifery care and the relatively high job autonomy of Dutch midwives. Innovations in the organisational structure that focus on continuity of care for pregnant individuals, job satisfaction for midwives and building a sustainable workforce may result in an increase in the retention of midwives. These innovations would ensure that women and their babies receive the best care possible.

Chapter 6 describes a qualitative study on established midwives' perceptions on supporting NQMs in practice**.** NQMs in the Netherlands perceive the adaptation to new responsibilities as difficult due to the autonomous nature of- and required accountability

for the work they face in practice. This paper explores the perceptions of experienced midwives regarding: (1) the performance- and transition into practice of newly qualified midwives, and (2) their supporting role in this transition. The research design was a qualitative study with focus groups. Experienced midwives' perceptions were explored by means of seven semi-structured focus groups (N=46 participants). Midwives perceived NQMs as colleagues who could not handle all their tasks and responsibilities. They perceived NQMs as less committed to the practice organisation. Support in community-based practices was informally organised with a lack of orientation. In the hospital-based setting, midwives offered an introduction period in a practical setting, which was formally organised with tasks and responsibilities. Experienced midwives recognised the need to support NQMs; however, in practice, they faced barriers. The differences in experienced midwives' expectations of NQMs and reality seemed to depend on the NQMs' temporary working contracts and -context, rather than the generational differences that experienced midwives mentioned. Dutch midwives prioritised their work with pregnant individuals and the organisation of their practice above supporting NQMs.

Chapter 7 describes the main findings of a Delphi study among maternity care stakeholders. Research shows that NQMs do not feel sufficiently confident and competent in their work during the period following graduation. NQMs start work as registered midwives without any formal transition support. This could impact the quality of care they provide. The aim of this study is to seek consensus with stakeholders concerning viable components of support for Dutch NQMs. A Delphi study was conducted among maternity care stakeholders. Sixteen statements derived from previous studies were assessed in the course of two rounds. These stakeholders (N = 61) completed an online questionnaire that included spaces for opinions and remarks. They agreed that there should be an introductory support period for NQMs, involving performance feedback and backup from fellow midwives during shifts. NQMs should be mentored or given group coaching by internal or external midwives. Such support should be tailored to the NQMs' needs. Stakeholders agreed about the responsibilities of the professional group on supporting NQMs in practice, and on the importance of providing proper orientation periods. The importance of a stable work environment did not find consensus, while previous research suggested otherwise. This study highlighted the importance of transition support at the workplace; however, implementation of this support is hindered by organisational barriers. Improving employment conditions and support for NQMs in policymaking could help them to achieve their midwifery quality targets.

Chapter 8 summarizes and discusses the main findings of this thesis, addresses the methodological considerations, and the implications for practice for educators, for policymakers, and for research. In this thesis, we found differences in midwives' attitudes and behaviour towards the socialization and support of NQMs in practice, towards the learning and development needs of NQMs in practice, towards the expected levels of organizational and managerial competence of NQMs, and towards responsibility for the organization of the practice. This thesis also identified differences in perceptions about NQMs' level of competence during their period of transition-into-practice and in attitudes towards work and home life. Established midwives valued working in practice, and valued employability and availability for the job, as suggested by the study of intentions to leave the profession. Building a sustainable midwifery workforce requires recognizing and valuing differences in midwives' competences, attitudes, and abilities, and valuing these differences in the organization of midwifery care. NQMs and experienced midwives in the Netherlands are highly engaged in their work in maternity care. NQMs are significantly more engaged than experienced midwives. Determinants of midwives' positive wellbeing are various factors, such as working with colleagues and 'with women', together with trainable personal resources, such as resilience and optimism. One in three midwives intend to leave the profession. Determinants of intentions to leave, and reasons for leaving the profession are a combination of high workload, practice owner roles and responsibilities, and family responsibilities. Components of support for NQMs as agreed by stakeholders include proper induction in practice, expansion of tasks and responsibilities with performance feedback from practice owners or managers, 24/7 back-up during a shift, and mentoring and coaching on work experiences. Systemic, organizational, and cultural aspects of midwifery care hinder the implementation of formal support. Establishing a transition period for all NQMs in their first year of practice was recommended, supported by stable employment combined with practice support. NQMs cannot work at the competence level required for a locum midwife. Components of support on which there is consensus among stakeholders can be implemented at local and regional level, where practice owners and managers should take responsibility for implementation. Design-based research is recommended to further develop detailed support components based on existing literature. At local or regional level, participatory action research can be used to implement these components in a specific region. Regarding midwives' wellbeing, periodic measures of their wellbeing in practice, their intentions to leave the profession and their intentions to remain in the profession are recommended for intervention and to build or enhance a sustainable midwifery workforce.

CHAPTER 10

Samenvatting

Dit proefschrift beoogt bij te dragen aan de kennis omtrent het welzijn en de ondersteuning van startende verloskundigen (SV) in de Nederlandse geboortezorg. We identificeerden de werkeisen en hulpbronnen zoals ervaren door SV die werkzaam waren in de wijk en in het ziekenhuis. In de volgende hoofdstukken lag de focus op de perspectieven van stakeholders in de geboortezorg aangaande de transitie van SV naar de praktijk, het welzijn van SV en ervaren verloskundigen en de determinanten die daarop van invloed waren en op de intenties van verloskundigen om de praktijk te verlaten.

Hoofdstuk 1 betreft een algemene introductie van het onderwerp, de probleem- en doelstelling van dit proefschrift. In dit hoofdstuk is uitleg gegeven over de concepten transitie naar de praktijk, welzijn in het werk en de begeleiding van SV tijdens deze transitie. Ook zijn de organisatie van de geboortezorg en de opleiding van verloskundigen in Nederland toegelicht. Het theoretisch model, onderliggend aan alle verschillende studies, het Job Demands-Resources model is toegelicht. De volgende onderzoeksvragen zijn beantwoord:

1. Hoe percipiëren startende verloskundigen hun transitie naar de werkplek en hoe wordt deze transitie begeleid of ondersteunt?

2. Wat zijn de percentages van welzijn van startende en ervaren verloskundigen in de praktijk en welke determinanten zijn geassocieerd met welzijn en intenties om het beroep te verlaten?

3. Wat zijn de gewenste en uitvoerbare componenten van begeleiding van startende verloskundigen in de transitie van opleiding naar de praktijk?

Hoofdstuk 2 exploreert in een kwalitatief onderzoek de ervaringen van SV die na hun afstuderen in de wijk (eerstelijns) zijn gaan werken. Doel van dit onderzoek was om een inventarisatie te maken van werkeisen en werk- en persoonlijke hulpbronnen. Middels groepsinterviews bestaande uit vijf groepen met SV zijn in totaal 31 participanten bevraagd over hun ervaringen. Met behulp van een thematische content-analyse zijn uitkomsten gegenereerd.

Het werken als waarnemer werd door SV ervaren als werkeis, wat impliceert dat zij meestal werken voor verschillende praktijken en daardoor om moeten gaan met verschillen in regionale afspraken en protocollen. De werkbelasting door de hoeveelheid diensten, alsmede de administratieve en organisatorische taken waren voor SV nieuw en belastend. Hulpbronnen waren vooral het werken met zwangeren alsmede de ondersteuning van collega's (mits beschikbaar) en peers (ex-medestudenten verloskunde). Grenzen kunnen stellen, flexibiliteit en relativeringsvermogen werden

ervaren als persoonlijke hulpbronnen, terwijl perfectionisme en bewijsdrang als persoonlijke uitdaging. Adequate ondersteuningssystemen zijn aanbevolen voor het vinden van een balans tussen werk en privéleven. Dit kan door ervaren verloskundigen in te gaan zetten als mentoren en door de tijdelijke arbeidsovereenkomsten om te zetten naar stabiele arbeidsrelaties.

In **Hoofdstuk** 3 staan de ervaringen van klinische werkende SV centraal. Het doel van deze studie was om de percepties van klinisch werkende SV te inventariseren. Een kwalitatieve studie met semigestructureerde interviews werd uitgevoerd. Eenentwintig SV werden individueel geïnterviewd. De transcripties werden geanalyseerd met behulp van thematische contentanalyse. Hoge werkdruk, functioneren als teamlid, aanvullende verloskundige vaardigheden en baanonzekerheid waren de ervaren werkeisen. Deelnemers ervoeren de afwisseling van het werk, het teamwerk, de sociale steun, het werken met zwangeren en de arbeidsvoorwaarden als hulpbronnen. Openheid voor nieuwe ervaringen, sociale vaardigheden, kalmte en nauwkeurigheid werden ervaren als persoonlijke hulpbronnen, en perfectionisme, zelfkritiek en faalangst als persoonlijke uitdagingen. De transitie als SV in het ziekenhuis vraagt van SV aanpassing aan nieuwe taken en verantwoordelijkheden. Sociabiliteit helpt SV om als volwaardig lid te functioneren in een multidisciplinair team; neuroticisme en perfectionisme belemmeren hen in hun werk. Duidelijke verwachtingen en een inwerkperiode kunnen SV helpen om zich aan te passen aan de praktijk. De inwerkfase zou beter ondersteund kunnen worden door studenten voor te bereiden op het werken in een ziekenhuissetting en door verwachtingen over de transitieperiode te managen.

Hoofdstuk 4 onderzocht het welzijn van verloskundigen in Nederland en de bepalende factoren daarvan. Internationaal rapporteert ongeveer 40 procent van de verloskundigen symptomen van burn-out, waarbij jonge en onervaren verloskundigen het meest kwetsbaar zijn. Er was een gebrek aan recent onderzoek naar burn-out onder Nederlandse verloskundigen. Het doel van deze studie was om het welzijn van verloskundigen in Nederlands inclusief de bepalende factoren daarvan te onderzoeken. Er werd een retrospectieve dwarsdoorsnede studie uitgevoerd met behulp van een online vragenlijst die bestond uit gevalideerde schalen die werkeisen, werk- en persoonlijke hulpbronnen, burn-outsymptomen en bevlogenheid maten. In totaal namen N=896 verloskundigen deel aan dit onderzoek, wat neerkomt op 28 procent van de praktiserende Nederlandse verloskundigen. De gegevens werden geanalyseerd met behulp van regressieanalyse. Zeven procent van de Nederlandse verloskundigen rapporteerde burn-out symptomen en 19 procent scoorde hoog op uitputting. Determinanten van burn-out waren alle gemeten werkeisen, behalve ervaringsjaren als verloskundige. Bijna 40 procent van de verloskundigen toonde een hoge bevlogenheid;

SV hadden de hoogste kans op een hoge bevlogenheid. Kwalificaties op master- of PhD-niveau en werkstatus werden geassocieerd met bevlogenheid, alsmede alle gemeten hulpbronnen. In tegenstelling tot eerdere internationale onderzoeksbevindingen was jong zijn en minder werkervaring hebben niet gerelateerd aan burn-out symptomen van Nederlandse SV.

Hoofdstuk 5 beschrijft een mixed-methods studie waarin de intenties van Nederlandse verloskundigen om in het beroep te blijven zijn onderzocht, naast de redenen om daadwerkelijk te stoppen. Deze studie heeft als doel om het percentage van- en de vertrekredenen in kaart te brengen. We gebruikten een mixed-methods design met een kwantitatieve vragenlijst (N=726) gevolgd door een tweede deel met kwalitatieve interviews (N=17) met verloskundigen die waren gestopt met de uitvoering van hun beroep. Bijna een derde van de respondenten overwoog het beroep vaarwel te zeggen. De beslissing om daadwerkelijk uit het beroep te stappen was het resultaat van een proces waarin verloskundigen eerst probeerden zich aan te passen aan hun werkomstandigheden, gevolgd door gevoelens van frustratie en uiteindelijk gevoelens van verminderde betrokkenheid bij het werk. In vergelijking met internationale cijfers vonden we een lager percentage verloskundigen dat overwoog het beroep te verlaten. Dit zou verklaard kunnen worden door de verschillen in de organisatie van de verloskundige zorg en de relatief hoge autonomie van de Nederlandse verloskundigen. Innovaties in de organisatiestructuur die zich richten op continuïteit van zorg voor zwangeren, werktevredenheid voor verloskundigen en het opbouwen van een duurzaam personeelsbestand kunnen leiden tot een grotere retentie van verloskundigen.

Hoofdstuk 6 beschrijft een kwalitatief onderzoek naar de percepties van de zittende groep verloskundigen ten aanzien van startende verloskundigen. Dit artikel onderzoekt de percepties van ervaren verloskundigen met betrekking tot: (1) het functioneren en de overgang naar de praktijk van SV en (2) hun ondersteunende rol in deze overgang. De opzet was een kwalitatieve studie met focusgroepen. De percepties van ervaren verloskundigen werden onderzocht door middel van zeven semigestructureerde focusgroepen (N=46 deelnemers). Verloskundigen zagen SV als collega's die nog onvoldoende zicht hadden op al hun taken en verantwoordelijkheden. Ze ervoeren als minder toegewijd aan de praktijkorganisatie. De ondersteuning in de praktijken was informeel georganiseerd met een gebrek aan inwerken. In de ziekenhuissetting kregen SV een introductieperiode, die formeel georganiseerd was met opbouw in taken en verantwoordelijkheden. Ervaren verloskundigen erkenden de noodzaak om SV te ondersteunen, maar in de praktijk liepen ze tegen barrières aan. De verschillen tussen de verwachtingen van ervaren verloskundigen over SV en de realiteit leken eerder af te hangen van de tijdelijke arbeidscontracten en werkomgeving dan van de

generatieverschillen. Nederlandse verloskundigen gaven voorrang aan hun werk met zwangeren en de organisatie van hun praktijk boven het ondersteunen van SV.

Hoofdstuk 7 omvat een Delphi-studie onder stakeholders in de geboortezorg naar het belang en de uitvoerbaarheid van ondersteuning van SV. SV gaan aan de slag als geregistreerde verloskundigen zonder formele ondersteuning. Dit kan gevolgen hebben voor de kwaliteit van de zorg die ze verlenen. Het doel van dit onderzoek is om consensus te bereiken met belanghebbenden over haalbare onderdelen van ondersteuning voor Nederlandse SV. Er werd een Delphi-studie uitgevoerd onder belanghebbenden in de kraamzorg. In twee ronden werden zestien stellingen uit eerdere studies beoordeeld. Deze stakeholders (N = 61) vulden een online vragenlijst in. Er was overeenstemming over het instellen van een transitieperiode voor SV waarbij zij feedback krijgen op hun werk en ondersteuning van collega-verloskundigen tijdens de dienst. SV moeten ook een mentor of groep coaching aangeboden krijgen, begeleid door ervaren verloskundigen en afgestemd op de behoeften van de SV. Over het belang van een stabiele werkomgeving bestond geen consensus, terwijl eerder onderzoek anders suggereert. Dit onderzoek benadrukte het belang van transitiesupport op de werkplek; de implementatie van deze ondersteuning wordt echter belemmerd door organisatorische barrières. Verbetering van de arbeidsvoorwaarden en ondersteuning van SV in beleid kan helpen om de kwaliteit van verloskundige zorg te kunnen waarborgen.

In **Hoofdstuk 8** zijn de belangrijkste bevindingen van alle studies samengevat, inclusief methodologische implicaties en de betekenis van de uitkomsten voor de praktijk, het onderwijs en onderzoek. De verschillen in de houding en het gedrag van verloskundigen ten aanzien van de socialisatie en ondersteuning van SV in de praktijk, ten aanzien van de leer- en ontwikkelingsbehoeften van SV, ten aanzien van de verwachte niveaus van organisatorische en leidinggevende competentie van SV en ten aanzien van de verantwoordelijkheid voor de organisatie van de praktijk waren opmerkelijk. Daarnaast werden ook verschillen in percepties over het competentieniveau van SV tijdens hun transitie naar de praktijk gevonden, alsmede in gedrag en attitudes ten opzichte van de combinatie van werk- en privéleven. Gevestigde verloskundigen waardeerden de inzetbaarheid en beschikbaarheid voor het werk van hun collega's, zoals ook bleek uit de studie naar vertrekintenties. Een duurzaam inzetbare beroepsgroep veronderstelt het erkennen en waarderen van verschillen in competentieniveaus, in houding en gedrag en het waarderen van deze verschillen in de organisatie van de verloskundige zorg. SV en ervaren verloskundigen in Nederland zijn bevlogen in hun werk, wat geassocieerd is met variabelen als het werken met collega's en 'met zwangeren', samen met trainbare persoonlijke hulpbronnen, zoals veerkracht en optimisme. Eén op de drie verloskundigen

heeft intenties om de werkplek te verlaten. Determinanten hiervan zijn een combinatie van hoge werkdruk, rollen en verantwoordelijkheden als praktijkeigenaar en het hebben van een gezin thuis. Het instellen van een transitieperiode voor alle SV in hun eerste jaar werd aanbevolen, ondersteund door een stabiele werkomgeving in combinatie met support in de praktijk. SV kunnen nog niet functioneren op het competentieniveau dat vereist is voor een waarnemend verloskundige en dit wordt om die reden afgeraden. Voor de support van SV was consensus onder stakeholders over het inwerken, over opbouw van taken en verantwoordelijkheden met feedback van praktijkeigenaren of managers, en over 24/7 back-up tijdens een dienst en het instellen van mentoring en coaching. Op lokaal en regionaal niveau kunnen deze componenten worden geïmplementeerd, waarbij ontwerpgericht onderzoek wordt aanbevolen om deze componenten verder te ontwikkelen en specifiek voor bepaalde regio's te kunnen implementeren. Met betrekking tot het welzijn van verloskundigen worden periodieke metingen van het welzijn van verloskundigen in de praktijk, hun intenties om het beroep te verlaten en hun intenties om in het beroep te blijven, aanbevolen.

Appendices

Curriculum Vitae

Liesbeth Kool was raised in a little village on a dairy farm with her parents and three older siblings. She earned her bachelor's degree in Pedagogy at the University of Applied science in Rotterdam. She then completed her post bachelor's degree in supervision and coaching in 1997 and became a registered coach and supervisor. In 2010 she completed a master's degree in educational science at the Open University in Heerlen. She graduated with a thesis on midwives' self-directed learning at the workplace.

Her working career started in different positions in social and healthcare. During her career, she developed an interest in workplace learning and the professional development of healthcare professionals. She explored her interests in supporting healthcare professionals during her training and teaching activities in nursing and midwifery.

Liesbeth has had a faculty appointment at the academy midwifery Amsterdam and Groningen for 20+ year. Next to her work as a teacher and study coach, she contributed to a project team who developed a midwifery bachelor programme. Recently, she was a co-developer of a joint degree master of midwifery in the Netherlands. In addition, she contributes since 2018 to the post-bachelor course Professional Coaching and Supervision at Groningen from the Hanze University of Applied Science. She works as senior educator and supervises coaches during their training.

In 2017 she started her PhD at the UMCG in Groningen, at the LEARN chair group. In this PhD, her interests and skills in both research and coaching supervision became intertwined.

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I would like to thank my employer, the Academy of Midwifery Amsterdam and Groningen (AVAG), the Inholland University of Applied Sciences and the National Organization for Scientific Research (NWO) for making this PhD trajectory possible. With their financial grant and their cooperation during this trajectory, I was able to complete this trajectory.

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I would also like to thank all the interviewees and participants in our various studies. They shared their experiences and insights with us. More than 1000 midwives contributed to this thesis. I am grateful for their participation, without their willingness to participate we would not have had these results. Furthermore, i also felt supported by their participation, which underlines the importance of this research topic.

Working with students, both bachelor and master students, is always inspiring. During my whole career, they work as job resources. A special big thank you to all the students who contributed to this thesis, by transcribing interviews and with their input during their own theses related to my topic. It has been valuable and inspiring to my own research.

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