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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 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 (Pairman et al., 2016). Newly qualified midwives are fully responsible and accountable for providing care to their clients from the moment of graduation (or registration) (Thompson et al., 2011). International research shows that the weight of responsibilities in the first year of practice can

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negatively influence NQMs' professional confidence as well as the overall quality of the provided care (Kitson-Reynolds et al., 2014, 2015).

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 (De Vries et al., 2013). Second, NQMs in other countries are supported in their transition from student to registered midwife (Avis et al., 2013; Henshaw et al., 2013; Pairman et al., 2016). In the Netherlands, formal support programs for NQMs do not exist. Third, in The Netherlands 72% of NQMs work as a locum midwife (explained in textbox 1) in primary care during their first years in practice (Kenens et al., 2017), as opposed to most other developed countries, where NQMs are usually employed by a hospital and work in a hospital setting (Avis et al., 2013; Pairman et al., 2016; Skirton et al., 2012).

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 (Offerhaus et al., 2015). These increasing referral rates could threaten in the long term the unique choice for women in the Netherlands to give birth at home.

Textbox 1. Explanation of working as a locum midwife in The Netherlands.

> 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 independence (www.belastingdienst.nl, Belastingdienst Nederland, 2018).

International studies on NQMs show that factors such as reality shock (Van der Putten, 2008), applying a different midwifery philosophy of care (Barry et al., 2013; Hobbs, 2012) and delay in securing employment and work allocations make the first years a very demanding period for NQMs (Clements et al., 2012). Studies on work resources for NQMs show that positive support and mentorship from colleagues (Clements et al., 2012; Pairman et al., 2016), working in continuity of care models (Cummins et al., 2015; Fenwick et al., 2012), and postgraduate preceptorship programs are associated with increasing confidence and competence (Hobbs, 2012; Pairman et al., 2016).

International research shows a gap in knowledge about the specific work and personal characteristics of NQMs (Pairman et al., 2016). 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 (Tong et al., 2007).

The Job Demands-Resources (JD-R) model (Bakker and Demerouti, 2007) was used as a theoretical framework (Fig. 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 (Bakker and Demerouti, 2007) and has been widely used for different (healthcare) professions, which allowed us to compare our results with other professions and occupations (Schaufeli and Taris, 2014). 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 (Schaufeli and Taris, 2014). In addition to work characteristics (job demands and job resources), personal resources were integrated in this model (Mastenbroek et al., 2014; Xanthopolou et al., 2007). 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 (Schaufeli and Taris, 2014).

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.

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 (Bakker and Demerouti, 2007; Schaufeli and Taris, 2014; Xanthopoulou et al., 2007). 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

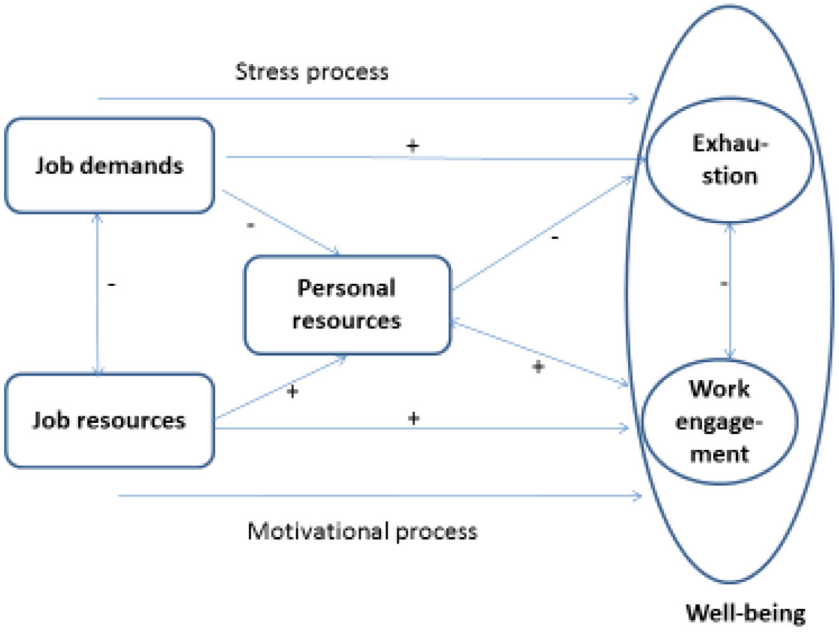

Fig. 1. theoretical model: JD-R model (Bakker and Demerouti, 2007).

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 labelled, 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, Centrale Commissie Mensgebonden Onderzoek, 2018) 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 min. 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 (Table 1), 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 Fig. 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 (2014), for example work overload, job insecurity, and time pressure as job demands; and positive client contacts, task variety and autonomy as job resources.

Job demands

Important job demands (Fig. 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 organisational 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 full-time 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

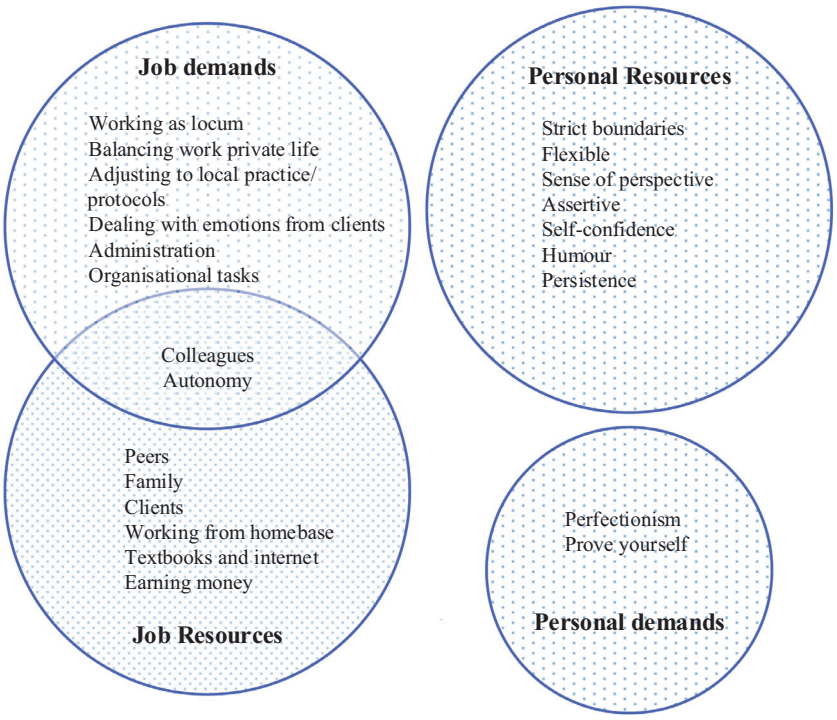

Fig. 2. Job demands, job resources and personal resources experienced by Dutch primary care midwives ($N = 31$).

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 Fig. 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 (Fig. 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 (De Vries et al., 2013), 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 (Jaarsma et al., 2008; Teunissen and Westerman, 2011). In our previous study (Feijen-de Jong et al., 2017) 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, Benner, 2001), 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 (Pairman et al., 2016; *Fenwick et al., 2012*). 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 (Sweller, 1994).

Comparing job demands on NQMs with other occupations and professions in the Netherlands (Schaufeli and Taris, 2014), 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 (Cummins et al., 2015; Fenwick et al., 2012) and support from colleagues (Clements et al., 2012; Fenwick et al., 2012; Pairman et al., 2016) 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 (Clements et al., 2012; Fenwick et al., 2012; Pairman et al., 2016). 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 (Pairman et al., 2016; Henshaw et al., 2013).

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 (Schaufeli and Taris, 2014). Furthermore, financial rewards as job resource show also similarity with our results (Schaufeli and Taris, 2014). 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 (Schaufeli and Taris, 2014) and health professions (Mastenbroek et al., 2014; Van den Berg et al., 2017). 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 and Westerman (2011). Mastenbroek et al. (2014) 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 (Kenens et al., 2017). 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. (2017) 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% 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 (Kenens et al., 2017).

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.

Conflict of interest

None declared.

Ethical approval

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

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2018.10.012.

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