# Midwives' perceptions of the performance- and transition into practice of newly qualified midwives, a focus group study

Kool, Liesbeth; Schellevis, François G.; Bax, Irma; Jaarsma, Debbie A.D.C.; Feijen-de Jong, Esther I.

*Published in:*
Women and Birth

*DOI:*
10.1016/j.wombi.2022.03.001



*Publication date:*
2022

Women and Birth xxx (xxxx) xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth

Original research

# Midwives' perceptions of the performance- and transition into practice of newly qualified midwives, a focus group study

Liesbeth Kool [a,b,c,*], François G. Schellevis [d,e], Irma Bax [a,b,c], Debbie A.D.C. Jaarsma [f], Esther I. Feijen-de Jong [a,b,c]

[a] Department of Midwifery Science, Amsterdam Public Health Research Institute, VU University Medical Center, Amsterdam, The Netherlands
[b] Department of General Practice & Elderly Medicine, University of Groningen, University Medical Centre Groningen, The Netherlands
[c] AVAG (Midwifery Academy Amsterdam Groningen), Dirk Huizingastraat 3–5, 9713 GL Groningen, The Netherlands
[d] Department of General Practice, Amsterdam Public Health Research Institute, Amsterdam University Medical Centers, location VUmc, Amsterdam, The Netherlands
[e] NIVEL (Netherlands Institute for Health Services Research), Otterstraat 118, 3513 CR Utrecht, The Netherlands
[f] Wenckebach Institute for Education and Training, Center for Education Development and Research in Health Professions, LEARN, University Medical Center Groningen, University of Groningen, Hanzeplein 1, 9713 GZ Groningen, The Netherlands

ARTICLE INFO

*Keywords:*
Midwifery
Perceived social support
Employee orientation programmes
Newly qualified Midwives
Mentoring
Coaching

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.

## 1. 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

* Corresponding author at: Department of Midwifery Science, Amsterdam Public Health Research Institute, VU University Medical Center, Amsterdam, The Netherlands.
*E-mail addresses:* liesbeth.kool@inholland.nl, e.kool@umcg.nl (L. Kool), f.schellevis@nivel.nl (F.G. Schellevis), irma@loonline.com (I. Bax), a.d.c.jaarsma@uu.nl (D.A.D.C. Jaarsma), e.i.feijen-de.jong@umcg.nl (E.I. Feijen-de Jong).

https://doi.org/10.1016/j.wombi.2022.03.001
Received 2 November 2021; Received in revised form 13 February 2022; Accepted 5 March 2022

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 [17]. 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.

## 2. 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 [18].

### 2.1. Theoretical framework

In this study we used the organisational socialisation theory as theoretical framework [19], 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 [19]. 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 Fig. 1.

### 2.2. 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.

### 2.3. 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.

### 2.4. 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

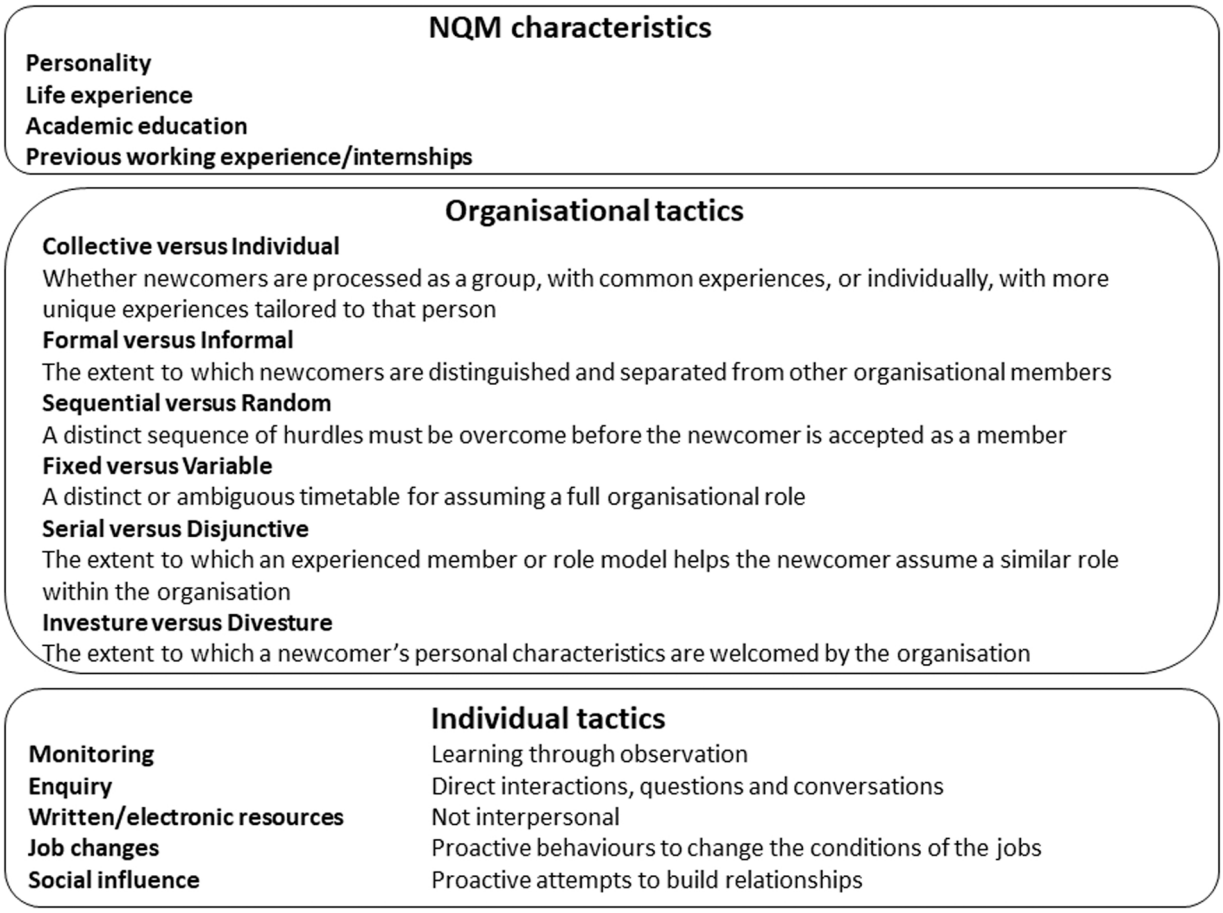


**Fig. 1.** Theoretical framework of organisational socialisation [20].

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.

### 2.5. 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.

### 2.6. Analysis

We performed a thematic content analysis, starting with an inductive approach. First, two researchers open coded all the transcripts [21]. 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 (Fig. 2).

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.

## 3. 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%).

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.

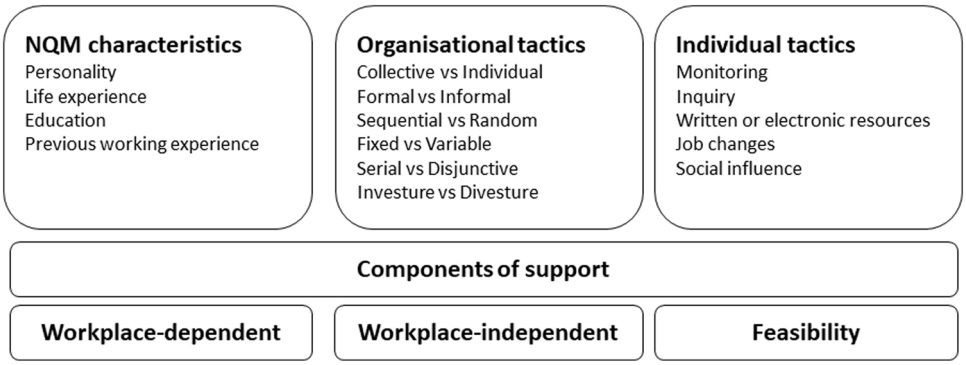


**Fig. 2.** Initial code tree for the analysis of seven focus groups of Dutch experienced midwives' perceptions of supporting NQMs in practice.

**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) |

### *3.1. 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)

### 3.2. Transition into practice

As shown in Fig. 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.

### 3.3. Community-based practice

After graduation, NQMs must be prepared to work as a locum, whereby orientation programmes 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)

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)

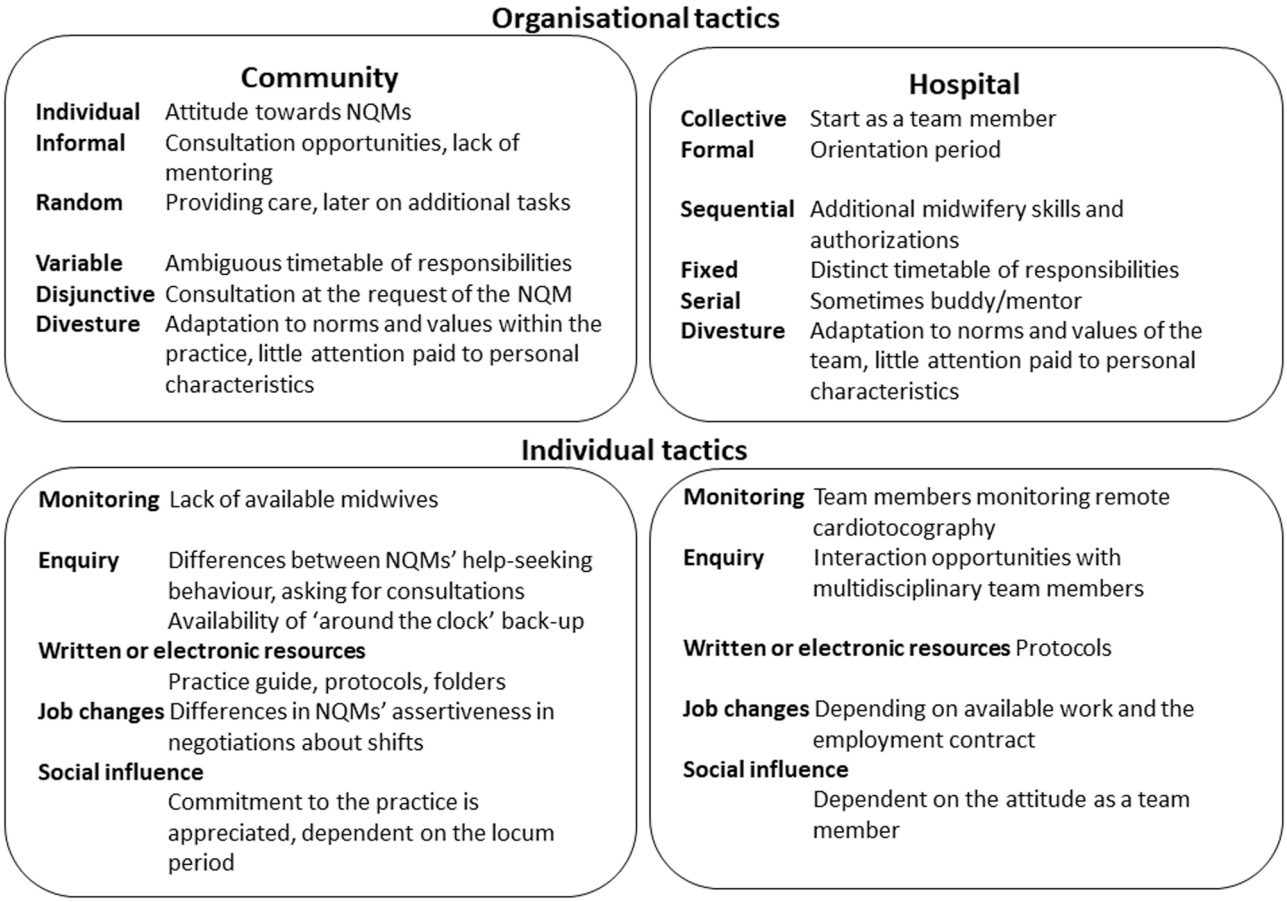


**Fig. 3.** Organisational and individual tactics, based on perceptions of Dutch experienced midwives (N = 46).

### 3.4. 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.

### 3.5. 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.

### 3.6. Workplace dependent

According to the participants (Fig. 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)

### 3.7. 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

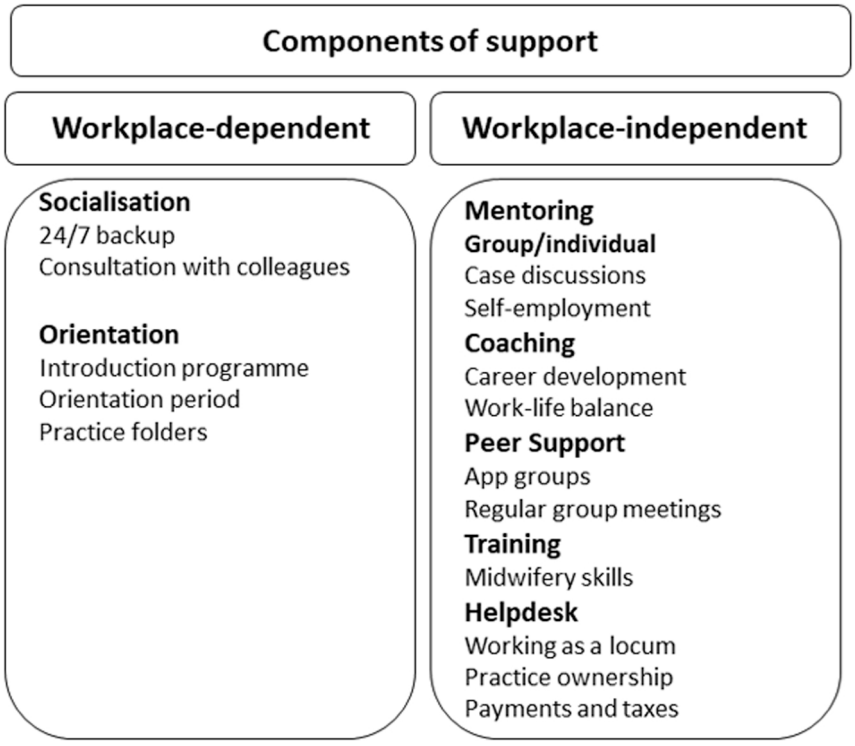


**Fig. 4.** Components of support for Dutch NQMs, based on seven focus groups comprising Dutch experienced midwives (N = 46).

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.

### 3.8. 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.

## 4. 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 [6,22] This requires high levels of professional autonomy and competency [22], 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 [28]. 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 [23,24]. For instance, the importance placed work-life balance has changed over the different generations, whereby commitment to the organisation has decreased with successive generations [23]. 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 [24].

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 [22]. 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 [25]. 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 [1,2,14,26]. 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 [27]. 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.

### *4.1. 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.

## 5. 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.

## 6. 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.

*Statement of Significance*

*Problem*

Dutch newly qualified midwives (NQMs) perceive the adaptation to their new role and responsibilities as difficult due to the autonomous work in practice after graduation. The need for support is recognised by NQMs in previous studies. Dutch experienced midwives' perceptions about support for NQMs in practice has not yet been studied.

*What is already known*

Previous research on NQMs recognises structured support from experienced midwives as effective in increasing levels of competence and confidence. Positive support by an experienced midwife as a mentor leads to reassurance and perceived safety for NQMs, it promotes better performance and competence and increases positive learning experiences. The main sources of formal support for NQMs are experienced midwives who are employed within or outside the facility (mentors) and informal support from the midwifery team.

*What this paper adds*

This paper adds knowledge about the perceptions of experienced midwives towards NQMs in practice and the (lack of) transition support for NQMs from experienced midwives. One main barrier for providing support for NQMs seemed NQMs' employment status. Temporary contracts in the hospital and working self-employed in the community might be an explanation for the lack of support experienced midwives provide for NQMs.

## Funding

This work is part of the research programme Doctoral Grant for Teachers with project number 023.012.012, financed by the Netherlands Organization for Scientific Research (NWO). The NWO has no involvement with the content of this article.

## Ethical considerations

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

## Conflict of Interest

None.

## Acknowledgements

None.

## Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2022.03.001.

## References

[1] L. Kool, E.I. Feijen-de Jong, F.G. Schellevis, D.A. Jaarsma, Perceived job demands and resources of newly qualified midwives working in primary care settings in the Netherlands, Midwifery. 69 (2019) 52–58, https://doi.org/10.1016/j.midw.2018.10.012018.

[2] L.E. Kool, F.G. Schellevis, D.A. Jaarsma, E.I. Feijen-De Jong, The initiation of Dutch newly qualified hospital-based midwives in practice, a qualitative study, Midwifery. 83 (2020), 102648, https://doi.org/10.1016/j.midw.2020.1026483.

[3] M. Gray, A. Malott, B.M. Davis, C. Sandor, A scoping review of how new midwifery practitioners transition to practice in Australia, New Zealand, Canada, United Kingdom, and the Netherlands, Midwifery. 42 (2016) 74–79, https://doi.org/10.1016/j.midw.2016.

[4] ⟨www.wetten.overheid.nl⟩ [Internet]. Wet op de beroepen in de gezondheidszorg. [Act on professions in individual healthcare 1993]. [cited 2021 18 Dec]. Available from: ⟨https://wetten.overheid.nl/BWBR0006251/2021–07-01⟩.

[5] Midwifery in the Netherlands. [cited 2022 Jan 21]. KNOV. Available from: ⟨https://www.europeanmidwives.com/upload/filemanager/content-galleries/members-map/knov.pdf⟩.

[6] R.J. Kenens, R. Batenburg, A. Kasteleijn, Cijfers uit de registratie van verloskundigen: Peiling 2016, Nivel,, Utrecht, 2017.

[7] P.M. Offerhaus, D. Korfker, A. de Jonge, K.M. van der Pal, B. Scheepers, T.L. Lagro-Janssen, Midwives and variation in referral decisions during labour, Patterns in Primary Midwife-led Care in The Netherlands (2015) 103.

[8] I. Freckelton, Regulation of health practitioners: Opportunities and developments for plaintiffs, Precedent 79 (2007) 29–35.

[9] A.E. Carroll, The high costs of unnecessary care, JAMA 318 (18) (2017) 1748–1749, https://doi.org/10.1001/jama.2017.16193.

[10] E. Kitson-Reynolds, P. Ferns, A. Trenerry, Transition to midwifery: Collaborative working between university and maternity services, Br. J. Midw. 23 (7) (2015) 510–515, https://doi.org/10.12968/bjom.2014.22.9.660.

[11] E.K. Reynolds, E. Cluett, A. Le-May, Fairy tale midwifery—fact or fiction: The lived experiences of newly qualified midwives, Br. J. Midw. 22 (9) (2014) 660–668, https://doi.org/10.12968/bjom.2014.22.9.660.

[12] V. Clements, J. Fenwick, D. Davis, Core elements of transition support programs: The experiences of newly qualified Australian midwives, Sex. Reprod. Healthc. 3 (4) (2012) 155–162, https://doi.org/10.1016/j.srhc.2012.08.001.

[13] M. Kensington, N. Campbell, E. Gray, et al., New Zealand's midwifery profession: Embracing graduate midwives' transition to practice, New Zealand College Mid. J. 52 (2016) 20–25, https://doi.org/10.12784/nzcomjnl52.2016.3.20-25.

[14] S. Pairman, L. Dixon, E. Tumilty, et al., The midwifery first year of practice programme supporting New Zealand midwifery graduates in their transition to practice, New Zealand College J. 1 (52) (2016), https://doi.org/10.12784/nzcomjnl52.2016.2.

[15] D. van der Putten, The lived experience of newly qualified midwives: A qualitative study, Br. J. Midw. 16 (6) (2008), https://doi.org/10.12968/bjom.2008.16.6.29592.

[16] M. Avis, M. Mallik, D.M. Fraser, 'Practising under your own pin'– a description of the transition experiences of newly qualified midwives, J. Nurs. Manag. 21 (8) (2013) 1061–1071, https://doi.org/10.1111/j.1365-2834.2012.01455.x.

[17] Belastingdienst. Toezichtplan arbeidsrelaties. [cited 2022 04 Feb]. Availbale from: ⟨https://download.belastingdienst.nl/belastingdienst/docs/toezichtplan-lh0071z1fd.pdf⟩.

[18] B.C. O'Brien, I.B. Harris, T.J. Beckman, D.A. Reed, D.A. Cook, Standards for reporting qualitative research: A synthesis of recommendations, Acad. Med. 89 (9) (2014) 1245–1251, https://doi.org/10.1097/ACM.0000000000000388.

[19] G.T. Chao, Organizational socialization: Background, basics, and a blueprint for adjustment at work, in: S.W.J. Kozlowski (Ed.), The Oxford Handbook of Organizational Psychology, Oxford University Press, 2012.

[20] C. Phillips, A. Esterman, A. Kenny, The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses, Nurse Educ. Today 35 (1) (2015) 118–124, https://doi.org/10.1016/j.nedt.2014.07.011.

[21] J. Green, N. Thorogood, Qualitative Methods for Health Research, Sage, 2018.

[22] R. De Vries, M. Nieuwenhuijze, S.E. Buitendijk, Members of Midwifery Science Work Group. What does it take to have a strong and independent profession of midwifery? lessons from the Netherlands, Midwifery 29 (10) (2013) 1122–1128, https://doi.org/10.1016/j.midw.2013.07.007.

[23] S. Stevanin, A. Palese, V. Bressan, K. Vehviläinen-Julkunen, T. Kvist, Workplace-related generational characteristics of nurses: A mixed-method systematic review, J. Adv. Nurs. 74 (6) (2018) 1245–1263, https://doi.org/10.1111/jan.13538.

[24] S. Lyons, L. Kuron, Generational differences in the workplace A review of the evidence and directions for future research, J. Org. Behav. 35 (S1) (2014) S139–S157, https://doi.org/10.1002/job.1913.

[25] C. Alexander, J. Millar, N. Szmidt, K. Hanlon, J. Cleland, Can new doctors be prepared for practice? A review, Clin. Teacher 11 (3) (2014) 188–192, https//doi.org/10.1111/tct.12127.

[26] L. Dixon, S. Calvert, E. Tumilty, et al., Supporting new Zealand graduate midwives to stay in the profession: An evaluation of the midwifery first year of practice programme, Midwifery 31 (6) (2015) 633, https://doi.org/10.1016/j.midw.2015.02.010.

[27] R. Fang, M.K. Duffy, J.D. Shaw, The organizational socialization process: Review and development of a social capital model, J. Manag. 37 (1) (2011) 127–152, https://doi.org/10.1177/0149206310384630.

[28] Kool L., Feijen-de Jong EI, Mastenbroek NJJM, Jaarsma ADC. Midwives' occupational wellbeing and its determinants. A cross-sectional study among newly qualified and experienced Dutch midwives. 2021; Manuscript submitted for publication.