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RESEARCH

Exploring the Experiences of Midwifery Preceptors Using the Differentiated Job Demands–Resources Model

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ABSTRACT

Objective: To explore midwives' experiences of precepting in relation to the demands of clinical practice.

Design: Secondary, supplementary qualitative data analysis.

Setting: Virtual interviews.

Participants: A total of 18 midwives (16 certified nurse-midwives and 2 certified midwives) who practiced in New Jersey.

Methods: We used data from a primary study of in-depth, semistructured interviews conducted from June 2023 to February 2024. We used qualitative description methodology and analyzed data using content analysis. We organized relevant codes using the major categories of the differentiated job demands–resources model, in which job demands are classified as hindrances or challenges and resources that can mitigate strain are identified.

Results: We found that precepting had a paradoxical effect on respondents' well-being. In the absence of adequate resources, precepting exacerbated exhaustion and in some cases led respondents to reduce or withdraw from teaching responsibilities. Conversely, when supported by collegial collaboration, shared responsibility, and personal agency in accepting students, precepting was a meaningful source of professional purpose and renewal.

Conclusions: Although precepting can foster professional engagement and renewal, it may also increase strain and contribute to burnout, particularly within health systems already facing staffing shortages and high turnover. The dual nature of precepting in midwifery underscores the role of system-level support in sustaining the midwifery workforce and clinical education.

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Growing the midwifery workforce is one important strategy to address the shortage of reproductive and perinatal health care providers in the United States. The United States has a shortage of all perinatal health care providers and a disproportionate shortage of midwives (American Association of Colleges of Nursing, 2024; Farb, 2023). In the United States, there are 11 obstetricians and 4 midwives per 1,000 live births. Most other developed countries have a large proportion of midwives in the perinatal care workforce and much larger perinatal workforces that include physicians and midwives. For example, the United Kingdom has 11 obstetricians and 43 midwives per 1,000 births, and Germany has 27 physicians and 30 midwives per 1,000 births (Tikkanen et al., 2020). A robust perinatal workforce is associated with improved perinatal health outcomes, increased access to care, and better patient experiences (National Conference of State Legislatures, 2024). Growing the midwifery workforce requires a twofold approach: retaining midwives who are already in the workforce and increasing the number of those entering the workforce.

The first step in growing the workforce involves retaining experienced midwives who are already in the workforce. Only 55% of midwives certified by the American Midwifery Certification Board (2025), the accrediting body of certified nurse-midwives (CNMs) and certified midwives (CMs), report working full-time, and an estimated 15% report not working within the field of midwifery at all. Like other health professions, the midwifery workforce is also threatened by high rates of burnout. In a large study

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Clinical education is a critical yet understudied aspect of midwifery education; midwives who educate students balance competing demands from patients, learners, and systems.

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investigating burnout among CNMs/CMs, 40.6% of midwives met criteria for burnout, and contributors to burnout were the practice environment and workload (Thumm et al., 2022). Burnout was associated with professional withdrawal in the forms of absenteeism, organizational turnover, and leaving the profession (Dyrbye et al., 2019), all of which contribute to workforce instability and exacerbate the existing shortage of perinatal care providers.

The second part of growing the workforce involves expanding the educational capacity to educate more midwifery students in the United States. Although the number of entrants to the midwifery profession has been steadily increasing, it is not sufficient to meet maternity care demands. From 2016 to 2021, the number of CNM/CM students in educational programs accredited by the Accreditation Commission for Midwifery Education increased by 28.8%, and these students are increasingly racially and ethnically diverse (Farb, 2023). According to a 2023 report from the U.S. Government Accountability Office, barriers to increasing the number of student midwives include the cost of education and the lack of availability of clinical education sites with a midwife preceptor (Farb, 2023). A midwife preceptor is an experienced midwife who mentors, teaches, and supervises a midwifery student one-on-one during the provision of clinical care to patients.

Literature Review

Clinical education is essential to growing the midwifery workforce because it forms a core component of midwifery education and must be guided by experienced health care providers to ensure quality. Clinical education builds on didactic education and allows the student to integrate knowledge with hands-on learning to build clinical decision-making skills. To enter the profession, midwifery students are required to successfully complete clinical education with experienced midwives to achieve the required clinical competencies and become safe beginning providers. Unlike graduate medical education, which receives federal support in exchange for training medical students (Villagrana, 2022), midwifery clinical precepting is not supported through federal funding and relies on informal networks of midwives, program directors, and administrators. Some midwifery programs provide clinical education placements for their students, whereas others require students to find their own clinical education placements. Some educational programs have affiliations with health centers that allow for clinical precepting by faculty. The result, very often, is that experienced midwives voluntarily (or occasionally for minimal compensation) precept students during their regular clinical hours.

Clinical precepting requires additional time, attention, and compassion. Midwifery preceptors teach students in the clinical setting, demonstrate and supervise hands-on skills, model patient-centered care, review cases, provide guidance on critical thinking, and review and co-sign documentation of care—all while accomplishing their own professional responsibilities (Lazarus, 2016). In addition to educating students, ideally preceptors also promote the socioemotional well-being of their students. Clinical precepting exists within a health system already taxed by high levels of burnout and turnover (Thumm et al., 2022, 2024), factors that decrease public trust in health care systems and increase moral injury and vicarious trauma among providers (Kendall-Tackett & Beck, 2022; Shorey & Wong, 2022).

Clinical precepting can be a paradoxical experience. Experienced midwives reported that despite experiencing some negative aspects of precepting, they continue to precept out of their love for their profession and desire to educate the next generation (Blumenfeld et al., 2024). In another analysis from this study, we identified the role of large institutions in supporting or hindering preceptors (Alspaugh et al., 2025). However, we felt that the day-to-day mechanics of precepting while working clinically had not been fully explored in our study or other research. Therefore, we conducted the current study to explore midwives' experiences of precepting in relation to the demands of clinical practice.

Theoretical Framework

We used the differentiated job demands–resources model to guide our data analysis, including how we organized and integrated codes. At the heart of the original job demands–resources model (Bakker & Demerouti, 2007) lies the assumption that whereas every occupation may have its own specific risk factors associated with job stress, these factors can

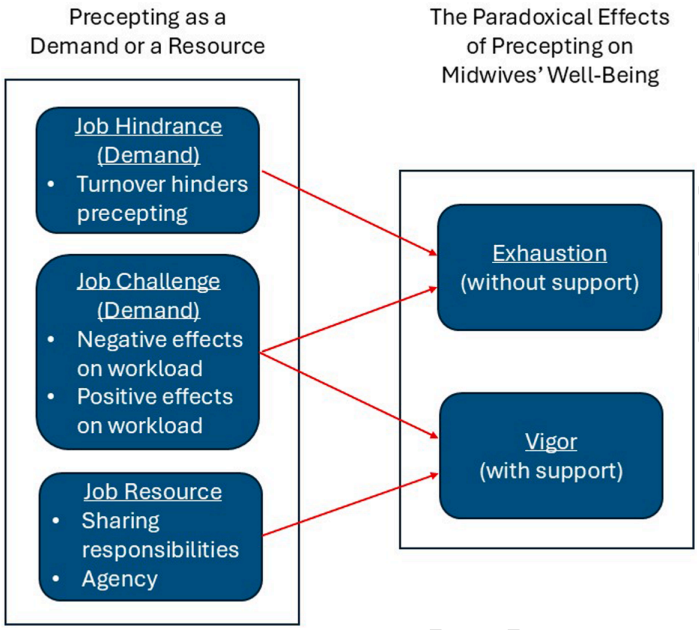

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Figure 1. Categorical organization of findings using the modified job demands–resources model. For a full description of the model, see Van den Broeck et al. (2010).

be classified into the two general categories: job demands and job resources. This overarching model can be applied to various occupational settings irrespective of the particular demands and resources involved. This model was further refined in the differentiated job demands–resources model proposed by Van den Broeck et al. (2010), in which job demands are differentiated as job challenges and job hindrances. Job hindrances are understood as aspects of a job that create obstacles to personal development and performance and lead to stress and disengagement, whereas job challenges are aspects of a job that both are demanding and have the potential to contribute to personal growth, learning, and motivation. This differentiation helps to explain why some job demands have positive effects such as motivation and engagement (challenges), whereas others lead to strain and burnout (hindrances) (Van den Broeck et al., 2010). Job resources are aspects of a job that are helpful to development and engagement. Taken together, these hindrances, challenges, and recourse can lead to either exhaustion, a component of burnout indicating resource depletion, or vigor, the energy to work in an enthusiastic and capable manner. How these concepts manifested in our study can be found in Figure 1.

Methods

Design

This study was a secondary analysis of qualitative data. We conducted the original qualitative study using in-depth, semistructured interviews conducted virtually to better understand the motivators and barriers to growing the midwifery preceptor workforce among a sample of midwives, physicians, and administrators ($N = 25$; Alspaugh et al., 2024). However, we also wanted to better understand how midwives integrate precepting into demanding clinical workloads because this is an important aspect of ensuring that midwives can serve as high-quality preceptors and care providers. A supplementary analysis provides an opportunity to conduct an in-depth investigation into an aspect of data collected that was not fully addressed in the primary study (Heaton, 2004). Our purpose was to conduct an in-depth analysis of precepting within the context of clinical care using a new, more topically appropriate theoretical framework, the differentiated job demands–resources model. We focused on only the interviews of CNMs and CMs and used qualitative description to guide our approach to this specific research question (Sandelowski,

Burnout among health care providers, including midwives, is common and contributes to poor outcomes and turnover among health care providers.

2000, 2010; Willis et al., 2016). We chose qualitative description to stay close to the data and, thus, close to the clinical experiences of practicing midwives (Sandelowski, 2010).

Participants

Our original sample consisted of individuals who worked in the state of New Jersey as CNMs, CMs, physicians, or administrators involved in placing midwifery students in clinical settings. We employed convenience and purposive sampling methods to identify participants. We conducted convenience sampling through advertisements on the email listserv of the New Jersey Affiliate of the American College of Nurse-Midwives. We conducted a second round of interviews several months after the first round of interviews to expand the diversity of perspectives for maximum variation in our sample. For the second round, we recruited specifically for midwives of color through a statewide midwives-of-color group and through identification by the third author (J.B.). The study received approval from the institutional review boards of Rutgers University and the University of Tennessee, Knoxville, and we provided all participants with a waiver of informed consent before the start of the interviews. In this secondary analysis, we used only the data from the CNMs and CMs to best focus on precepting while providing patient care.

Setting

We conducted in-depth, one-on-one interviews virtually via Zoom.

Data Collection

The interview team included one trained qualitative researcher (A.A.) and three graduate students trained in qualitative coding and familiar with the topic of interest. All interviewers identified as female, and three identified as people of color. Whenever possible, racial concordance between interviewer and respondent was prioritized. None of the interviewers had prior relationships with the respondents, and we informed all participants of the study's purpose before their interviews. The interview guide (Supplemental Table S1) included questions about midwifery care broadly, experiences as preceptors, and practice environments.

Procedures

Before each interview in the primary study, we reviewed the waiver of informed consent and respondents provided verbal consent. Interviews averaged 40 min in length. Respondents received a $25 gift card as a token of appreciation for their time. The Zoom audio recordings of the interviews were professionally transcribed, and we reviewed them for accuracy. Each respondent selected a pseudonym to ensure confidentiality, and they are used herein to identify respondent quotes.

Data Analysis

In our primary study, we followed the steps of applied thematic analysis to guide data analysis and synthesis (Guest et al., 2012). For this secondary analysis, we used deductive content analysis to explore data within the context of our theoretical framework (Kyngäs et al., 2020). We used the web version of Atlas.ti for data management, coding, and analysis. The first author (A.A.) deductively created a preliminary codebook of open codes that we expanded through group consensus during the coding project. One member of the coding team coded an interview, and another member reviewed this coding; discrepancies were settled by consensus. Next, we organized our codes into categories and subcategories using the five categories of the modified job demands–resources model: hindrance, challenge, resource, exhaustion, and vigor. The entire research them collaboratively finalized the results.

Results

In total, we interviewed 18 respondents: 16 CNMs and 2 CMs. Their ages ranged from 31 to 62 years ($M = 47$), and they practiced as midwives for 2 to 28 years ($M = 13$). Of these respondents, 9 identified as White, 3 as Hispanic, 2 as Black/African American, 1 as Asian, and 3 as multiracial. All but 1 respondent was currently precepting or had recently precepted midwifery students. Regarding their workplaces, 12 worked in hospital-based practices, 3 worked in community-based practices, and 3 worked in the hospital and community.

Using the categories of the differentiated job demands–resources model to organize and code the data, we organized our findings using a modified job demands–resources framework (Figure 1). We identified two major categories: *Precepting as a Hindrance, Challenge, or*

Resource and *The Paradoxical Effect of Precepting on Well-Being.* Each of these major categories included related subcategories.

Precepting as a Hindrance, Challenge, or Resource. The first major category, Precepting as a Hindrance, Challenge, or Resource, represented how precepting affected clinical practice in three distinct ways, each identified as a subcategory: *Job Hindrance, Job Challenge,* and *Job Resource*.

Job Hindrance. The first subcategory, *Job Hindrance,* represented how precepting was a hindrance to being able to fully do all aspects of one's job. Many respondents described how difficult it was to precept while working in practices with significant shortages due to high levels of turnover. Several noted that the difficult practice environment during and after the COVID-19 pandemic exacerbated turnover in their practices. This turnover put further strain on those providers who stayed. Lupe shared the difficulty those in her practice had in dealing with what she described as the "burnout of practice turnover." The constant loss of providers and the need to educate their replacements hindered her ability to precept students:

> I would say a barrier [to precepting] for our practice at the moment is just the incredible amount of turnover that we've had and like burnout from practice itself might make it hard for some people to commit to taking a student.

Despite working in a practice that she described as very accepting of students, she was only recently able to start precepting midwifery students again after the start of the pandemic.

Another respondent, Sunny, worked at a practice that was not taking midwifery students at the time of data collection: "One of the things that our practice director is concerned about is that we're orienting lots of new providers and they think it will be too taxing to take on a student." The aftershocks of unprecedented turnover of health care providers following the pandemic include creating a barrier for practices to take on the clinical education of student midwives.

Job Challenge. The second subcategory, *Job Challenge,* represented how precepting was a challenge that had the potential to lead to growth in some circumstances. All practicing respondents described heavy clinical workloads, which included a large number of scheduled office visits that were often double-booked, many patients in labor, and insufficient time off between busy days. Precepting could exacerbate workload demands and lead to exhaustion or could mitigate workload demands and lead to vigor. All respondents shared how precepting added to their workloads. Dana explained how exhausted she felt after talking with patients and a student all day:

> Especially when we're in the office, we're talking to patients all day and I'm talking a lot more because I'm explaining what I'm doing. It's almost like what my brain is thinking is now being verbalized because I have a student, so I'm kind of teaching them what I'm doing, what I know in my head, and trying to explain that out loud, so I'm quite sick of hearing myself talk. … There's a lot more of that that happens with a student as opposed to when I'm by myself.

Another respondent, Marie Angelo, described how precepting interrupted workflow:

> When I'm going through my day, my documentation in the EMR [electronic medical record] is something that I do in the room because I bring their laptop into the room with me. So I'm typing and talking at the same time and documenting and clicking. … When you have a student, you're not doing any of that. So the workload is not only just teaching during the day, but it's my documentation that changes significantly. So my documentation is done that evening, the next day, the next day, or the next day.

Although precepting often introduces demands on time, in some instances it can be beneficial and help to support workload. Eventually students can see patients independently, and the student and midwife can divide patients. As Dana described, "'I'll go see one, you go see one. That way we don't get too, too backed up.' That ends up being a good thing." The help of a trained and capable student helped to make workloads more manageable. Julia described how students can significantly support patient education:

> I think the benefit is that they help with [patient] education. For example, if it's

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> contraception, if it's VBAC [vaginal birth after cesarean], if it's nutrition, so they have this background from their nursing or as they're reviewing, in their chapters, so that's a huge benefit.

Job Resource. The third subcategory, *Job Resource,* represented how precepting was helpful to the overall job of being a midwife. Many respondents described job resources in their work settings that supported them in their work as preceptors, including sharing responsibility and allowing for individual agency. Respondents spoke of various steps they and their employers took to support their ability to precept while providing high-quality patient care. Claudia described how midwives in her practice share the responsibilities of precepting: "Usually when we have a student, we all participate in their preceptorship. For example, in the practice there are usually two midwives that precept the same student … so that's a way to kind of balance the work." These practice-level adjustments gave preceptors the resources they needed to accomplish their tasks with energy and focus.

Respondents indicated that the ability to decide for themselves whether to precept was an important factor that improved their happiness with precepting and their jobs. This agency allowed them to consider work and home responsibilities when agreeing to precept a student. Robin explained,

> We're so lucky, I think, honestly, because we don't work with OBs [obstetricians] that dictate everything. … We have the voice and the power in our practice, so we discussed it and, you know, are you guys okay with taking this student, this is what her limitations are. So we all kind of have control over it, so I feel like we're really fortunate that no one above us is telling us, "You have to take these students."

However, agency without the necessary supportive resources could be problematic. Abby worked in a high-volume practice where many felt too busy to precept, and she received no support from her administrators when she agreed to precept: "Partially because I agreed to take on the student, my practice was OK with it, but they were like, they didn't ask me to do this, so they were basically like 'All right, that's on you. Good luck.'" Agency alone, in Abby's case, was insufficient to support precepting.

The Paradoxical Effect of Precepting on Well-Being. The second major category, *The Paradoxical Effect of Precepting on Well-Being,* represented how precepting functioned differently in the workplace depending on the hindrances, challenges, or resources of a given practice environment. The combined effects, however, generally led to one of two distinct outcomes that we identified as subcategories: *Exhaustion: Precepting Without Support* and *Vigor: Precepting With Support.*

Exhaustion: Precepting Without Support. Often practices did very little to prevent exhaustion and burnout for their providers, especially regarding precepting responsibilities, and this was represented by the first subcategory: *Exhaustion: Precepting Without Support.* Many respondents vocalized the high levels of exhaustion they experienced personally or saw within their practices because of being short-staffed, having high patient loads, and precepting simultaneously. One respondent, Katarina, had recently left her job and described an unreasonable patient workload as one of the reasons. When asked about burnout prevention at work, she replied, "I don't think anything's been done for burnout, unfortunately, at all. Hence my summer off because I was burning out. Just couldn't do it anymore, so I'm not starting again until September." Katarina noted that over the past several years, she had trained more than a dozen midwifery and physician assistant students. This dual patient care and teaching burden led her to search for a new job and take several months off between jobs.

Others dealt with the exhaustion caused by burnout by stepping away from precepting. Dana had not precepted a midwifery student since December, but even 6 months later she was still too exhausted to take another student:

> It's now July and I'm still like, "I can't take another one for a little bit" because it is, it's exhausting. It's tiring. It's just when it's also out of your normal routine, caring for a patient and just doing your thing, and then when you have another person involved, it's tiring. … When I'm seeing 30 patients a day and getting slowed down because I'm teaching as well, it's really difficult to maintain. … How do you fix that burnout so that way people don't feel this way for 8 months after you finish with a student?

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For these respondents, the demands of patient care and teaching without adequate resources were unsustainable and resulted in their need to step away from one or both roles.

Vigor: Precepting With Support. For many respondents the second subcategory, *Precepting With Support,* represented how precepting gave them purpose and reinvigorated their desire to work as midwives. Robin, the respondent mentioned earlier who collectively made decisions with the other midwives in her practice, precepted students because she was 1 year into clinical practice. She recalled the pivotal role her own preceptors played in her professional and personal development as a midwife: "You have to midwife the midwife students, right, if we're not doing that, you're missing the heart and soul of what we do." Many of our respondents shared similar sentiments and felt that the education of new midwives was a core component of their role, not an extraneous task. It was part of what gave their work meaning and provided personal and professional enjoyment.

Many respondents also noted that support in the role of preceptor allowed the partnership to further benefit them. Amparo precepted for years and had learned ways to ensure that precepting made her workload more manageable: "I feel like there's nothing more thrilling than seeing a student at a birth because I think that helps the rejuvenation, like, 'Okay, I now remember why I'm doing this.' That joy is, is really addicting." From assisting with a birth to doing a routine annual exam, respondents found teaching students as a way to remind them of their original joy and purpose in becoming midwives.

Other respondents such as Lupe discussed how precepting and a culture of learning help to protect against burnout among health care providers:

> I find that sort of for me [precepting] is renewing versus the idea that precepting students makes you burn out more. I mean, for me it's more a sense of renewal and it's affirmation when I watch a student do a really good job, interacting with a patient and doing a beautiful job, doing a delivery, that's renewal for me, that's restorative.

Conceptualizing precepting as a way to contribute to the profession gave respondents more energy and vigor to do hard jobs, gave them more sense of purpose, and provided meaning to their work. This was an important narrative amid an overwhelming climate of burnout in health care described by so many respondents.

Workplace support for precepting midwifery students may reduce burnout and enhance engagement, whereas poor support may exacerbate burnout and reduce preceptor participation.

Discussion

This study offers new insight into the paradoxical role of precepting in midwifery practice and reveals how precepting can function as a source of strain and a pathway to professional engagement. Importantly, our findings emphasize that the problem lies not in the act of precepting itself but rather in the unsupportive and under-resourced environments in which it often occurs.

Sustaining and growing the midwifery workforce is not possible without midwives who serve as clinical preceptors. If midwives do not precept, there is no workforce pipeline and the already concerning provider shortage will worsen (Farb, 2023). Several respondents explicitly connected staffing shortages with a dwindling capacity to precept, which creates a dangerous cycle whereby workforce attrition further constrains opportunities to educate new midwives. This is important within the current midwifery workforce, where burnout has been found to affect two in five midwives (Thumm et al., 2024). Notably, however, practice-level leadership was identified as a modifiable characteristic with a large effect on burnout, which offers opportunities to address workforce churn (Thumm et al., 2022).

Yet unlike medical education in which precepting is often formalized, compensated, and expected as part of professional duties, midwifery education relies heavily on informal voluntary networks of clinicians (Villagrana, 2022). Midwives are asked to precept without formal preparation, structured training, or consistent payment or recognition. In medical education, teaching is embedded within clinical workflow and linked to institutional funding streams that incentivize and support large hospital systems across the country. Respondents described this disconnect and noted the lack of opportunities for formal training in clinical education. Some mentioned efforts such as continuing nursing education modules, preceptor trainings in New Jersey, and

reaccreditation requirements as steps in the right direction, but these efforts are insufficiently widespread or standardized. The absence of consistent, high-quality preparation for precepting increases job strain and risks undermining the quality of clinical education itself, thereby hindering the next generation of midwives who might not have been midwifed into their professional roles well (Krause, 2016; Penney, 2016).

Our findings highlight respondents' strong desire for recognition and institutional acknowledgment of their teaching roles. This echoes a broader literature in organizational psychology in which researchers found that meaningful work should be reinforced through social and institutional recognition (Grant & Parker, 2009). Respondents in our study valued peer support and appreciation from their colleagues and leadership and noted that without it the act of precepting could feel invisible and burdensome. Addressing this gap through enhanced professional support, including administrative support for those precepting, could be a low-cost, high-impact intervention to improve midwife satisfaction and retention (Boone et al., 2024).

The tension between agency and obligation in precepting also warrants attention. Although the agency to choose whether and when to precept was valued by respondents, it was not sufficient to sustain a reliable education system. In contrast, the medical education model makes precepting largely obligatory through formalized teaching roles and compensation. This raises an important question: How can midwifery integrate some of the successful features of medical education without undermining midwives' autonomy or overburdening already strained providers? One promising path forward may be to formally embed precepting expectations within employment agreements and support those duties with protected time, formal recognition, and compensation for the individual or the employer.

Implications

This study demonstrates how the differentiated job demands–resources model offers a valuable lens through which to capture the multifaceted nature of precepting. Precepting is mentally, emotionally, and logistically demanding, but with adequate institutional and collegial support it can become a meaningful invigorating part of midwifery practice. Several respondents described precepting as a reminder of their professional purpose and as a way to reconnect with the values that drew them to midwifery in the first place. This mirrors findings from a study by Thumm et al. (2024), who identified professional renewal and personal satisfaction as protective factors against burnout in midwifery. Our study furthers these insights by identifying which aspects of clinical work hinder and support midwives in their dual roles. By strategically transforming precepting from a job hindrance into a job challenge and ultimately a job resource, health care organizations have an opportunity to sustain their clinical workforce and invest in its future.

Finally, precepting holds potential as a workforce stabilization strategy. In environments marked by high turnover, having midwifery students embedded in clinical care with a supportive preceptor can help to offset staffing gaps, ease provider workloads as students become more independent, and create a workforce pipeline from within in a generative process identified in a recent systemic review by Folkvord and Risa (2023). Integrating students as learners and contributing members of care teams offers a promising intervention for workforce sustainability and midwife well-being.

In addition, a healthy and engaged workforce can lead to improved patient outcomes. In a preliminary study specific to the midwifery workforce, Freeney and Fellenz (2013) found that increased work engagement among midwives was associated with improved quality of care. Overwhelming evidence in the nursing literature indicates that the well-being of providers affects patient outcomes. In a recent systematic review and meta-analysis, Li et al. (2024) concluded that burnout among nurses was associated with lower health care quality, safety, and patient satisfaction. Within maternity care, nurses who reported burnout were four times more likely than those who did not experience burnout to leave necessary care undone (Clark & Lake, 2020). Centering and prioritizing the health and well-being of the provider is crucial for overall high-quality patient care. Researchers suggested that the "triple aim" proposed by the Institute for Healthcare Improvement (Berwick et al., 2008), which included improving the patient experience of care, improving the health of the population, and reducing per capita cost of care, should be expanded to the "quadruple aim" with provider well-being as a fourth aim (Bodenheimer & Sinsky, 2014; Fitzpatrick et al., 2019). Researchers should specifically explore how training future generations of health care providers, from physicians to midwives to advanced practice

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nurses, can be done to best support learners and providers alike. Focusing on this specific dyadic combination offers significant, long-term return on investment.

Limitations

Our study has important limitations that must be considered. Our sample was specific to only one state, and midwifery scope and freedom of practice vary greatly across the United States. Although state regulation was recently found not to be associated with professional burnout among midwives (Thumm et al., 2024), there may be other factors that vary geographically that affect burnout and workforce quality of life. Furthermore, the U.S. midwifery workforce also varies greatly from the international midwifery workforce, so not all these findings will be applicable internationally.

Conclusion

Our findings suggest that the priority should not be to relieve midwives of the responsibility to precept but rather to redesign clinical environments so that precepting is not just tenable but also meaningful and restorative. By investing in training for preceptors, formalizing teaching roles, compensating clinical education, and recognizing midwives' educational contributions, institutions can transform precepting from a burden into a value-added part of midwifery practice.

SUPPLEMENTARY MATERIALS

Note: To access the supplementary materials that accompany this article, visit the online version of the *Journal of Obstetric, Gynecologic, & Neonatal Nursing* at http://jognn.org and at https://doi.org/10.1016/j.jogn.2025.10.002.

CONFLICT OF INTEREST

The authors report no conflicts of interest or relevant financial relationships.

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Supplemental Table S1: In-Depth Interview Guide for Midwives

Demographic Questions

We're going to start by doing a few quick demographic questions to get to know a little bit more about you and your background.

1. What is your gender?
2. What is your racial and ethnic identity?
3. How old are you?
4. How many years have you been working as a (midwife/physician/practice administrator)?
5. How would you describe your practice setting? (If needed, can prompt with geographic location, patient population)
6. Have you ever precepted midwifery students before?
7. Can you please select a pseudonym that we will use to label your interview and in publication? This helps ensure anonymity.

OK, we are about to start the interview. Please remember not to use the given name of anyone during our conversation, but instead, you can refer to them by a pseudonym or by their job title. The interview will last anywhere from 30 to 45 minutes, and I'll primarily be asking you a series of questions. You can always select not to answer a question and may ask for clarification if the question isn't clear. We will also be doing a card sorting activity to help identify and prioritize the most salient barriers to precepting midwives.

Interview

First, we will talk a little bit about midwifery care.

- Can you explain the midwifery model of care as it relates to your practice?
- What do you see as the value of midwifery in health care? In your specific practice?
- Would you mind sharing your history with precepting midwifery students?
- How do you get connected to the midwifery students you precept? (i.e., does the school send them? do you know them beforehand? etc.)
- Can you tell me about your own experience being precepted when you were in midwifery school?
- How do you think this impacted the way you precept?
- If especially bad or good experience, can you give a few examples or more detail? How did this shape your professional growth?
- How do your patients tend to respond to learners, both midwifery students specifically and all allied health care students?

Next, we will talk a little bit more about your specific clinical setting.

- Can you tell me about your clinical practice? What does a typical day or week look like in terms of your workload?
- Tell me how having a midwifery student changes your day.
- What additional tasks do you have when precepting? Are there any tasks you can delegate?
- Examples: student progress notes, talking to faculty, extra time with patients or students
- How does precepting change your patient care? How does it change your time at work and outside of work?
- Is there anything you do, or that your practice does, to prevent preceptor burnout?
- Examples: rotating who has a student, letting it always be a choice, shared decision making)
- What are your favorite parts of precepting midwifery students?
- What are some tangible benefits of precepting midwifery students? Intangible ones?
- Who gets the money if money is involved?

Now, we're going to do some card sorting [shares screen with Freeform pulled up]. This will help us discuss some barriers to precepting midwifery students. These barriers have been identified in the literature and from our own stories and experiences. Can you help me identify which barriers are (1) relevant to your practice and are true to your own experiences and which are not relevant; and of those barriers that are relevant, (2) help me rank the barriers in order of most important to least important.

- Can you tell me a little bit more about what makes the biggest barrier such an impediment?
- Are there any other barriers not listed here that are relevant in your practice?
- Which barriers are under your sphere of influence?

(Continued)

Supplemental Table S1: Continued

Finally, we are going to talk about the process of making change in an organization.

- How would you describe the culture of your practice?
- Do you feel like you have a voice in decisions made for the entire practice?
- How does your practice approach educating/precepting students across health disciplines?
- What would make it easier for you to precept (or precept more frequently)?
- What could midwifery educational programs do to make precepting easier on you? Your practice? Your patients?
- Examples if needed: money, CE credits, better coordination, better prepared students

Q7 Q8

That's all the questions I have for you today. Is there anything else that we haven't discussed that you think is important for this conversation?

Please know that you can reach out with questions or additional thoughts or comments at any point. You have my/the PI's contact information on the waiver of informed consent. I will email the gift card to the email address you have provided after this call. Q9

Before you go, do you know anyone else who you think we should talk to in New Jersey about this topic? For example, a physician who heads a practice with midwives, a colleague involved in ACOG, or an administrator? Could you please share this information or share their information so we can reach out to them? Q10

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