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Developmental mentoring: New Zealand graduates' confidence grows when their needs shape the relationship

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# Developmental mentoring: New graduates' confidence grows when their needs shape the relationship

### Authors:

- Sue Lennox, PhD  
Lennox Midwifery Consultancy  
Educator & Facilitator, Lead Maternity Carer  
Midwifery Mentor, Professional Supervisor  
Expert Advisor, Director, Sky Blue House Limited  
Email [suelennox@skybluehouse.co.nz](mailto:suelennox@skybluehouse.co.nz)
- Maralyn Foureur  
Professor of Midwifery  
Centre for Midwifery, Child and Family Health Faculty of  
Nursing, Midwifery and Health  
University of Technology, Sydney

### ABSTRACT

**Background:** The transition from student midwife to practising midwife can be supported using the developmental mentoring approach. **Aim:** This paper describes a research project that explored group mentoring with four new graduate midwives and four experienced midwives. **Methods:** This longitudinal project used mixed methods to collect data over a period of one year. Data included three in-depth interviews with each participant along with quantitative data from contact logs, self-assessed confidence scales and analysis of practice outcome data. **Findings:** the four new graduate midwives were able to clearly identify their needs and how those needs could best be met. The most valued aspect of the mentoring support was the ability to discuss practice experiences with the mentors and to hear and learn from all the group members (both other graduates and mentors) during the group meetings. **Conclusion:** The developmental mentoring approach used in this project was strongly based on a philosophy of supporting the new graduates as competent novices. This approach enabled the new graduates to identify their own needs and decide how to have them met (Lennox, Jutel, & Foureur, 2012). The project appeared to support the new graduates to develop as confident and safe practitioners.

### BACKGROUND

The New Zealand maternity system is midwifery-led and depends upon a supply of safe and well educated midwives. This change to midwives taking full responsibility again occurred in 1990 and in the last 21 years midwives have become the predominant lead carers for women having babies in New Zealand (Guilliland & Pairman, 2010; Hendry, 2001). The changes have impacted the maternity system as a whole and in particular the way in which midwives are educated (Pairman, 2006). Undergraduate midwifery programmes aim to graduate practitioners who are competent to care for

women during pregnancy, labour and birth and for up to six weeks after the birth on their own responsibility; to provide care in both community and in hospital settings; to recognise problems; to work with and refer to other practitioners as needed (Te Tatau o Whare Kahu Midwifery Council of New Zealand, 2010). The experience of beginning practice is an area that has received increasing international and national interest over recent years (Clements, 2012; Rhéaume, Clément, & LeBel, 2011; van der Putten, 2008). The experience of entering practice was initially described by Kramer (1974) as 'reality shock' and more recently 'transition shock' which is "the most immediate, acute and dramatic stage in the process of role adaptation for new nurses" (Boychuk Duchscher, 2008; 2009, p. 1111). A New Zealand feminist phenomenological study found that new graduate midwives "enter a liminal phase for a short period where they are 'betwixt and between'" and yet at the same time, fulfil, and appreciate their responsibilities as autonomous practitioners (Kensington, 2006, p. 161).

A mentoring approach whereby the new graduate chooses an experienced midwife as a mentor is the model used in New Zealand to support new graduates to make their transition (New Zealand College of Midwives, 1996, 2000, 2008). In this approach the mentor's role is to assist the new graduate to identify her own learning needs, to help her critically reflect on practice, and to be available as a support throughout her transition year. This mentoring approach has also been used as the foundation of the Midwifery First Year in Practice programme—an initiative that was commenced and funded by the Ministry of Health in 2007 (Ministry of Health, 2007). There have recently been some calls to introduce an intern-type model for the first year whereby all new graduates would be required to spend the first year, or part thereof, in a hospital-based programme such as is the case for junior doctors (Cameron, 2010; Te Tatau o Whare Kahu Midwifery Council of New Zealand, 2011). A research report by Berridge, Sharpe, & Roberts (2007) on new graduate doctors strongly suggested that new graduates' confidence and competence were directly related to the quality of the support they received. The transition time has regularly been shown to be stressful for new graduates of many disciplines (Rochester, Kilstoff, & Scott, 2005; Scott & Yates, 2002).

Stress has been identified as inevitable for new practitioners however according to international evidence the perception of support increases new graduates' self-confidence (Boychuk Duchscher, 2008; Newton & McKenna, 2007; Oermann & Garvin, 2002; Oermann & Moffitt-Wolf, 1997). International studies also underline the limitations imposed on new graduates in hospital settings where "disenfranchisement and marginalisation of new graduates continues...[to] impact recruitment and retention of graduate nurses [internationally nurses includes midwives] and patient safety" (Morrow, 2009, p. 278). There appear to be factors embedded in the culture of the hospital work environment which have been identified in a number of studies that undermines a sense of safety for new graduates; fear of making mistakes, interactions with doctors and lack of support (Rhéaume, et al., 2011). Bullying both internationally and nationally has also been identified as a significant problem in nursing and midwifery (Ball, Curtis, & Kirkham, 2002; McIver, 2002; McKenna,

Smith, Poole, & Coverdale, 2003). Therefore descriptions of effective professional development support models for new graduates in practice need to be shared.

The needs of new graduate midwives during this potentially stressful transition time and how these needs are met is an issue that requires exploring. This paper describes research that examined a group mentoring model and provides a close examination of a developmental mentoring approach. It is based on a recent in-depth study of the mentoring of new graduate midwives conducted in New Zealand (Lennox, 2011). It is the most intensive study of mentorship of new graduate midwives undertaken so far. It provides detailed evidence about the appropriateness of a developmental mentoring approach within the New Zealand context and in particular for midwifery, but has been supported by studies from other disciplines as well (Chiles, 2006; Clark, 2004).

Developmental mentoring is a method of support that is well-established in a number of different settings; it is an adult-to-adult learning relationship, where the needs of the mentee frame the purpose of the relationship through individual negotiation and the increasing accomplishment of the mentee (Knowles, 1973, 1980). The developmental mentoring model is a partnership established with an end purpose in mind, such as to encourage confidence in a particular occupation or position. The purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of their role (Theobald & Mitchell, 2002). The plans and processes for achieving this end are purposely put in place by mutual dialogue and negotiation (Darling, 1984). The learning process is shared: the mentee is learning about a role or increasing her expertise, and the mentor is learning about the process of stimulating developmental changes (Clutterbuck, 2009; Daloz, 1986, 1999).

The developmental mentoring approach underpinned the study presented here. This paper explores the needs of four new graduates as they transitioned to confident midwife. It reveals how their transition was achieved through a unique group mentoring project. The following questions are explored to examine the question of what new graduates need and how their needs are met:

1. Why did the new graduate midwives in this study think they needed mentoring?
2. How often and why did the new graduates call on mentor support?
3. How did the new graduates get support, information and advice?
4. What aspects of mentoring did the new graduates find most valuable?
5. Did the new graduates gain confidence during their mentoring year?
6. Is there evidence that these new graduate midwives practised safely?

The response of the new graduates has provided rich descriptive data that can be used to understand the graduate perspective on mentoring and support the adoption of the developmental approach as a means of supporting health professionals in their practice transitions.

## SETTING UP THE GROUP MENTORING PROJECT

The group mentoring project was carried out in 2006, prior to the introduction of the Midwifery First Year in Practice (MFYP) programme in New Zealand. The project was prompted by a shortage of individual mentors for new graduate midwives in the region. In response to a request from four final year midwifery students, four senior midwives proposed a group approach to mentoring, as none was able individually to be a mentor. The group approach involved the ability to call on any one of the four mentors who established a twenty-four hour seven day a week (24/7) roster. In addition, the group held weekly meetings of all eight, new graduates and mentors to focus on discussing issues arising from the new graduates' practice. The detailed arrangements for contact and for how the meetings would operate were agreed between the group participants. The weekly meetings were held in the home of one of the new graduate midwives; were

conducted over a shared meal and were of two hours duration. A structured meeting format was agreed that saw the group begin with a 'round' of greetings and presentation of what issues each mentee wanted to discuss that day. One of the eight volunteered at each meeting to facilitate the conversation to ensure that everyone was heard and to keep the meeting to time. The meeting closed with another round of reflections on the issues discussed and the learning that had occurred.

## THE GROUP MENTORING STUDY

All eight participants agreed to take part in a research project carried out by one of the four senior midwives (Sue Lennox). The primary aim of this study was to describe the new group mentoring model in detail, and to explore whether group mentoring supported the new midwives to gain confidence. A secondary aim was to explore how the group mentoring model enabled the experienced midwives to support and pass on practice knowledge and wisdom to the new graduates.

## METHOD

As the mentoring project was a unique opportunity to explore various dimensions of new graduate mentoring, a naturalistic study evolved within a pragmatic paradigm, using a mix of both qualitative and quantitative data collection methods. Data were collected opportunistically as the project evolved, as this suited the practice context. The focus of the study was mapping the new graduates' development of confidence, their concerns and their needs. Also of interest were the mentors' responses to the new graduates' concerns and their evaluations of their own roles and responsibilities (the subject of a future article). The research involved collecting data on contacts made between new graduates and the mentors, audio-recording the weekly group meetings, interviews of each of the eight participants, three times over the course of the year, completion by the new graduates of a visual analogue scale of confidence, and a collation of data about the births that the new graduates attended during the course of the year. Quantitative data were analysed using simple descriptive statistics and qualitative data were subjected to thematic analysis (Braun & Clarke, 2006; Graneheim & Lundman, 2004). Ethical approval was granted by the Human Research Ethics Committee of Victoria University of Wellington.

## RESULTS

This section presents results from the data analysis according to the six questions listed earlier. Illustrative quotes from interviews have been used throughout and are identified according to which of the four new graduates was the source (New Graduate 1 (NG1) - New Graduate 4(NG4)).

### 1. Why did the new graduate midwives think they needed mentoring?

It was clear from the first interviews (undertaken prior to graduation) that although the soon-to-be new graduates saw the mentors' experience as potentially helpful, they also saw themselves as competent, responsible professionals upon registration. The soon-to-be new graduates were tentative but excited about their new role and keenly aware that they wanted mentor support to be available, in the background. The new graduates were each clear that they wanted an adult relationship with their mentors and not to be 'mothered': "I don't expect you to be there holding my hand 24 hours of the day" (NG1, 1st Interview). The new graduates believed the mentors' experience was the most important reason for seeking mentoring and would play a part in their becoming safe practitioners.

*But it's having that support, having that experience there and I think it is essential to be a safe practitioner ... [to have an] experienced mentor during that transition. It's a big jump, it's huge and it's just having that process there* (NG4, 1st Interview).

This new graduate also said that mentoring was connected to safety: "I want safety, really good outcomes for my women" (NG4, 1st Interview). Another reflected that the mentors would provide the new graduates with "... someone to bounce ideas off and challenge me" (NG2, 1st Interview). They

thought the role of mentors would be to guide and to help them to understand midwifery more fully. In particular, as students they knew that there were aspects of practice to which they were blind, such as how it felt to be on a pager and to be fully responsible for their own caseload.

*But I haven't been on the pager [as a Registered Midwife] you know what I mean and there are things that you don't get exposed to as a student. Everything that you have experienced as a student helps you in developing your practice but there are things that you don't necessarily get confronted with until you are out in practice. And having that support to say, "hello this is something new to me ..."* (NG4, 1st Interview).

They were aware that starting practice would involve a great deal that was new to them. Their responses suggested that once registered, they were prepared to take responsibility by asking for support should they need it; that they anticipated there would be situations they could not predict; and that when these occurred, they expected the mentors to be responsive and supportive. The interviews clearly showed the new graduates did not want or expect the mentors to attend births unless the new graduate asked. It was expected that other midwives would fulfil this role. Therefore the mentors would be unlikely to be with them if an unexpected emergency occurred, but that they saw the mentors' role in this situation was one of debriefing and support following the event.

*I don't see you actually coming to that [an emergency] but ... more as ringing once it's over. That's what I see [the mentor] asking, what do you think you did wrong or do you think I did that right or have I done the documentation okay or whatever. I think that would be quite good really to come back as a group [for reflection].* (NG1, 1st Interview).

The ability to call a mentor at any time was emphasised throughout the first interviews. The new graduates' appreciated that being able to call anytime was important but so too the opportunity to review and debrief their practice experiences in order for them to learn from these. NG4 and NG1 were aware that the year ahead would provide a big learning curve:

*Yes definitely [it] is really important and that I know that I can call and not feel hesitant about calling. But to be able to come and sit down and, and discuss something and to debrief and look how I could have done it differently or how I would like to do it and how I can achieve it ...* (NG4, 1st Interview).

The importance of not being hesitant about calling a mentor was underlined throughout the year by the new graduates. The importance of mentors "being there" to provide them with the reassurance they need, is reinforced in the comments below:

*Somebody who's going to be there for me next year when I'm out as a new grad to help me find... need anything clarified, any problems that I need answered, basically just to be there ...* (NG1, 1st Interview).

The sense of security provided by the notion of mentors being available 24/7 to receive calls is obvious in the quote below even a year after graduation:

*Well at the beginning it was the [on-call availability] 24 hours seven days a week. ... I have to admit [that] it was [my] knowing that [the mentors] were available if [needed] to actually be physically present* (NG1, 3rd Interview).

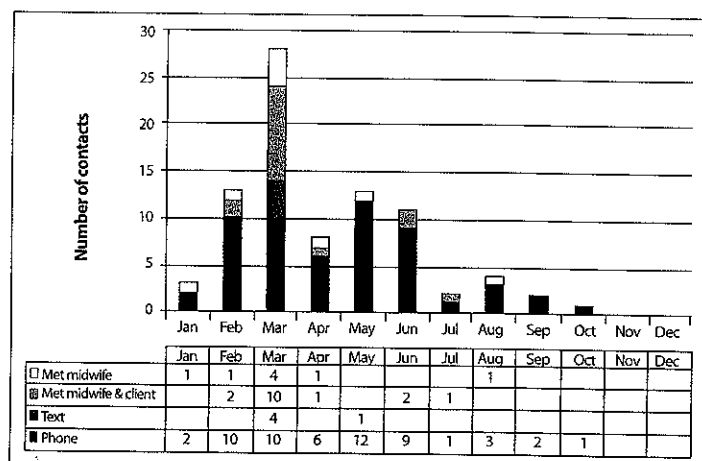
In response to a question about the effectiveness of the on-call mentoring system, one new graduate said:

*I don't know if I have ever had a moment where that [calling the mentor] hasn't answered my question. I have had moments where I have thought maybe I need to think about this more because I have been encouraged to think about it more... I have never felt like I have come away with nothing* (NG2, 2nd Interview).

## 2. How often and why did new graduates call on mentor support?

Findings are presented from the analysis of the logs that mentors kept of their on-call and face-to-face contacts with new graduates during the year, outside of the weekly meetings. As shown in Figure 1, mentors recorded 85 contacts with the four new graduates: 56 (66%) contacts were phone

Figure 1: Number, type and frequency of contacts between mentors and new graduates over a year



calls, 5 (6%) were text messages; on 8 (9%) occasions the mentor and midwife met without seeing the client, and on 16(19%) occasions they met together with the client.

Most of the contacts occurred in the first six months, with only 9 contacts from July onwards and with the last contact being a single call in October. Of the 16 contacts that involved the mentor being with the new graduate and her client (mostly at a birth), ten (62%) occurred in March. On average there were 3.1 contacts (2.6 by phone) for each of the weeks when there were contacts, with the busiest week of the year having 17 contacts recorded (including 4 texts and 5 phone calls).

Of the total number of calls, 46% were generated by one of the four new graduates. Two others generated 20% each, and one of the new graduates generated only 2% of calls. Eight per cent involved more than one new graduate and 4% were as a result of the mentor calling. While the new graduate who generated most contacts had twice as many phone contacts as the other two, she met face to face with a mentor less often.

The number of contacts between individual mentors and new graduates ranged from 11 to 27. Actually meeting in person with the new graduate (with or without her client) ranged between one and nine times.

Mentors recorded a brief description of the reason for each contact. These descriptions were found to fall into the following categories:

- Advice – where the new graduate was asking for information or advice
- Assistance – where the new graduate was asking for the mentor to give assistance (usually to attend a birth)
- Giving information – where the new graduate was giving the mentor information, often in terms of keeping her updated about a client
- Discussion – where the new graduate wanted to be able to discuss a situation and usually her feelings about it without needing advice or assistance
- Mentor initiated – there was one contact where a mentor phoned a new graduate to ask about a client's progress.

In summary, mentors were contacted by new graduates several times a week in the first half of the year, but there was considerable variation between new graduates in the numbers and types of contact they initiated. Two thirds of the contacts involved only a phone call for advice or information, while about a fifth involved the mentor meeting with the new graduate and her client (usually at a birth) and providing either background or face-to face clinical support. In the second six months, there were far fewer contacts and a greater proportion were contacts where the new graduate was seeking a discussion rather than asking for information, advice or assistance.

## 3. How did new graduates get support, information and advice?

The new graduates not only acted as responsible professionals with their clients, but also took responsibility for seeking the support that they

needed. Once mentor availability was assured, then the new graduates began to discriminate when, and whether to call and who was the most appropriate person needed at the time (a new graduate peer, mentor or senior midwife, obstetric registrar or consultant). They spoke of the need to think out the issues before asking for help from anyone. The ability to be proactive and seek expert opinion was balanced by the recognition that there were skills to knowing when and whom to call, and to think about why the calls were being made, in order to be clear about what they wanted. One new graduate described how she rang one of her peers first and then decided which calls were appropriate for mentors or for other services.

*When I haven't been sure I have ... called the midwives in the group first to see if they know because that's what we are going to be doing anyway and if they don't know I will contact a mentor. If it has been something that I had been questioning [such as the need] for referral I have just rung the hospital and been pointed in the right direction. (NG4, 2nd Interview)*

In the quote above "...called the midwives in the group..." refers to the other new graduates. Their group of four was an important source of support and strength to one another throughout the year (Darwin & Palmer, 2010; Johnson, 2007; Ritchie, 1999). Asking for help was not a reflex action for any of the new graduates; they thought about the reason for calling, whom and when to call, what to say and to whom. Sometimes the new graduates were challenged by hospital personnel who thought the mentors should have been contacted for particular information, rather than bothering hospital staff. One detailed how she had told them this was not the mentor's role, and she was within her rights phoning as a registered practitioner to ask for such information:

*So sometimes it has been a little bit difficult ... when I first rung up about something they said "this isn't where you're supposed to ring, who are your mentors" and were quite aggressive and I said to them "well actually I need to find out for myself what I need to do." (NG4, 2nd Interview)*

Contacting and communicating with others, then, is a key developmental milestone, but knowing who, when and why to call is only a beginning step. Later the learning appeared to be about knowing why certain information is appropriate for one person and not another, and how to give that information in a particular way. Consulting with doctors was mentioned as a time for finding the right words and form for communicating effectively. One new graduate found practising beforehand with other midwives at the hospital worked well:

*You have to put it in a coherent order... I actually do it in my head – what I am going to say to the consultant or registrar – before I go and say it... I will talk to the shift coordinator if it is a particularly good one or another midwife... I like pretty much like all of the midwives that work there. (NG2, 2nd Interview)*

Another midwife described how taking responsibility for being clear when consulting with doctors was part of being "the midwife":

*That's something I have to learn to do. I found it hard to do especially being new and finding the right words and all that kind of stuff. And feeling vulnerable in that position but knowing I have to do it because I am the midwife. (NG4, 2nd Interview)*

What information was appropriate for one colleague was not necessarily required by another; it depended on the role that person held and what it was the new graduate wanted from the dialogue, for example, for the shift coordinator on duty in the hospital:

*I mean... they just want to know what's going on; they just want to check in. Not give them heaps [of information] but just let them know that you're progressing well and there are no problems basically. (NG4, 2nd Interview)*

When seeking a consultant opinion however, she was "... more clear, I give a history, I say what's going on and say that I would like... if I am consulting I am usually wanting them to see the woman" (NG4, 2nd Interview). This new graduate understood there was more to communicating than finding

the right form or the right words to use. She described how she sought to collaborate and develop effective inter-professional relationships:

*I really try not to get defensive inside myself; I think it is really easy just to get defensive. But I am really aware of the fact that I want these people to be on my side, you know that I can communicate with them and have them on board with me. So I have been really aware about building those relationships and communicating with people. It becomes easier to do that you know with some of the obstetricians I have been making the effort, I have gone to some of the [antenatal] consultations – the woman with the anencephalic baby – and had discussions with the obstetrician, so they know I am there... so that they know that I exist, that I'm a midwife in the community and that I am proactive about things that I need to be proactive about. (NG4, 2nd Interview)*

Her confidence and self-awareness after only six months in practice show a level of sophistication in working with the system to achieve respectful and collaborative inter-professional relationships.

#### 4. What aspects of mentoring did new graduates find most valuable?

When the new graduates and the mentors were asked what it was about the group mentoring model that was most important, they all identified the regular group meetings as the key ingredient. Mentoring as a group was a unique aspect of this model. The new graduates felt that they were heard at the meetings, and as everyone focused on their particular story, it helped them reflect on the experience and distinguish what they might do differently, or not, if they met the situation again. As one new graduate reflected:

*... meetings [are] great and just having to say, well what to think about this, this and this, this is what I have done but what do you think? I look forward to them, I look forward to Mondays. I look forward to seeing what other people have been doing. I've found it helpful. (NG2, 2nd Interview)*

The experiences of their colleagues discussed at the group meetings added to their own meaning, so that their learning during those meetings was potentially quadrupled, as all four new graduates met and shared their different practice experiences:

*Yes it's good to meet and discuss and even when I don't have anything to discuss it's good to hear what other people have got and you are learning from that. (NG1, 2nd Interview)*

This signals the amount of new graduate learning which occurred whilst listening to one another's stories and the group discussions that inevitably followed (Cooper, 1995). This silent learning at the group meetings was acknowledged in the interviews. "It's quite scary sitting back and listening to what's going on this year. Really scary and also knowing that that could have been me in all those situations... you do learn from other people's things" (NG3, 3rd Interview). Listening to others meant the new graduates were processing different views and opinions and sorting out what learning should take priority for them.

The new graduates recognised that their mentors had different ways of approaching practice problems, and instead of finding this confusing, they seemed to relish the freedom it gave to make their own choices about what they would take or leave:

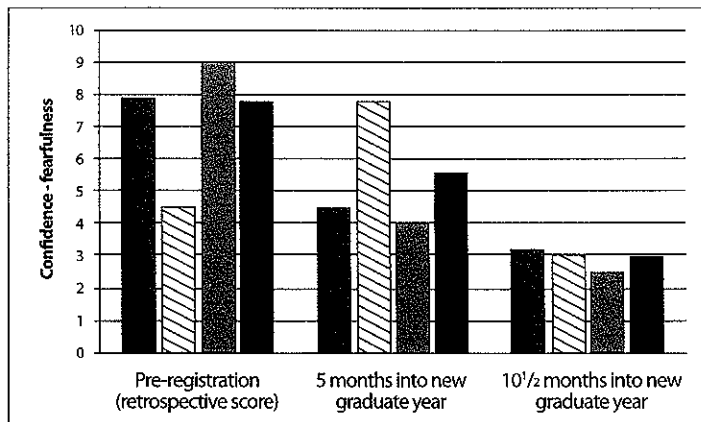
*... yeah the group process has been good too because everybody's actually had their own thoughts on that subject and I can then digest what everybody said and then you cement [your own thoughts] "ok so you have said that, that's that person"... I take on what everybody says and then I think "ok, alright, and so that was fine but really it is more that [person's approach] I want to take on board this time and maybe next week it [will be] more that [person's approach]." (NG1, 2nd Interview)*

Or even more simply expressed as: "It is quite interesting having a group I have found I have learnt lots" (NG4, 2nd Interview).

The new graduates and the mentors came to meetings voluntarily, as there was no compulsion to attend. Sometimes the new graduates had been up all



**Figure 2: Visual analogue scores of the four new graduates over the mentoring year**



(from 1=confident to 10=fearful) (each bar represents one of the new grad midwives – the bars are not labelled to protect the identity of the midwife)

night at a birth but felt the need to come to the group meeting anyway, as a resource for affirmation and feedback.

*I had been up since four that morning and then I had visits in the hospital, I was knackered but I came to the meeting because I really wanted to discuss it*

[Researcher asks] So you are actually finding these meetings helpful?

*Oh yeah, they are. I really wanted to go home and sleep but I came to the meeting to discuss it, just to kind of... as a new practitioner everything is new, you know, it was the first time I had dealt with this woman who had a VBAC (vaginal birth after a prior caesarean). (NG3, 2nd Interview)*

### 5. Did new graduates gain confidence during their mentoring year?

Although these new graduates viewed themselves as being competent at the start of the mentoring year, they realised their inexperience and were not confident practitioners. Their ratings on the confidence scales show that they assessed themselves as being quite fearful at the start of the mentoring year and gaining confidence during it (Figure 2).

The new graduates were asked at their second and third interviews to score their confidence on a 10-point visual analogue scale (from 1= confident to 10= fearful). At the half-way point (second interview), they also retrospectively estimated what their confidence had been as students looking ahead to the new graduate year. Figure 2 indicates that after a five month period of mentoring, three of the new graduates felt they had more confidence than at the student pre-registration stage; after ten and a half months, the level of confidence far outweighed their fears.

### 6. Is there evidence that new graduate midwives practise safely?

The women the new graduates cared for had similar rates of normal births and caesarean rates (67% normal birth rate, 25% caesarean rate) when compared to women cared for by other self-employed midwives in this district (65% normal birth rate, 25% caesarean rate). This was despite having a higher percentage of first time mothers in their caseload which can affect outcomes because first time mothers may have more interventions than mothers who have previously given birth. This reassurance is in line with the national statistics collected by Midwifery and Maternity Providers Organisation (MMPO) about new graduate outcomes and reported in the New Zealand College of Midwives Midwifery News (Dixon, 2010, p. 18).

## LIMITATIONS OF THE STUDY

This study is limited to the experiences of these four new graduate midwives in New Zealand and cannot be generalised to other new graduate midwives. The new group mentoring worked well for this project, which may have been due to setting up of carefully considered structures prior to the start of the project. The characteristics of the mentors may also have had an effect on outcomes making it difficult to replicate this study to other settings.

The role of a participant researcher has both benefits and drawbacks. There is potential for a power differential between the researcher and the researched which may affect the feedback received during the research. However, as van der Putten (2008, p. 356), another participant researcher found the participants in this study appeared relaxed about sharing their experiences with the researcher.

## DISCUSSION

In order for New Zealand to retain a midwifery-led, high quality, maternity service, the experience gained by midwives in their first year of practice is pivotal. This research has followed the progress of four new graduate midwives in their first mentoring year. The regular audio recorded mentoring meetings held throughout the mentoring year contributed to an understanding of the new graduates' concerns, needs and experiences, as they occurred. In addition this study has recorded the new graduates and mentors reflections about their year through a series of in depth interviews.

Developmental mentoring as provided by this group appears to offer the variety of support needed by new graduates in their first year of practice. The first identified need for the new graduate in this study was the ability to access an experienced midwife for respectful dialogue and support at any time. Each of the new graduates acknowledged the ability to call a mentor when they needed to as extremely important. The new graduates acted in ways that could be described as autonomous from the start. In that they sought the most appropriate person to whom to make a referral, telling them what they needed by using the right words and style of communication to achieve their ends. They learned early that being clear about the purpose of their discussion encouraged appropriate intervention and support and that the converse was also true. In this study the new graduates developed critical thinking skills at the weekly meetings where they were free to discuss their thoughts and to challenge or be challenged (Mezirow, 2003). The group meetings were scheduled according to the new graduates' wishes and 31 such meetings were held over the year. The capacity of a group of midwives to model respectful practice conversations was clearly appreciated. The new graduates showed they were intent on developing cooperative and collaborative practices as autonomous and responsible health professionals working within the scope of practice.

The New Zealand midwives' scope of practice and model of care ensures that the ICM definition of a midwife is fulfilled (International Confederation of Midwives, 2005). In Australia there is a perception that relatively autonomous models of midwifery practice based on one to one, continuity of care for women can only be provided by experienced midwives. However Davis et al (2011) argue that the continuity of care model of maternity care is also appropriate for new graduates so long as these graduates are well supported. When considered together with the evaluation of the Midwifery First Year in Practice programme, this present study reinforces the veracity of that argument (Lennox, 2011; Oliver, 2008).

## CONCLUSION

Mentoring provides the framework for supporting new graduates through the transition from new graduate to confident practitioner by. This research has found that new graduates were clearly able to identify and articulate their needs when new to practice. By choosing mentors with whom they could negotiate support these new midwives were provided with the security they needed to develop their practice confidence. One of the ways of becoming a confident and reflective midwife is to begin practice well supported and with time for dialogue with a mentor about recent and anticipated clinical scenarios.

This paper describes research about a group mentoring project which comprised four new graduate midwives and four experienced midwives. This group model of mentoring support during their first year appears to have supported the graduate midwife to develop confidence and may encourage self-governance. The findings from this study suggest that mentoring by experienced midwives enables the graduate to identify and actively seek the support she needs from appropriate professional sources to help her develop as a safe and competent practitioner.

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