Starting Life as a Midwife

An International Review of Transition from Student to Practitioner

Michelle Gray
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Introduction

A midwife is a person who supports a woman during parturition. The title midwife is not gender specific to women as midwives. The traditional meaning originated historically from Middle English; the prefix 'mid' means with, and the term 'wife' relates to the woman. Thus midwife means 'with woman'. Midwifery is one of the oldest practices, with the first recordings of lay midwives providing support to women documented in France in the fifteenth century (Connerton 2018). Today, midwifery is recognised as a profession that makes a considerable international contribution to the reduction in maternal and neonatal morbidity and mortality rates (International Confederation of Midwives (ICM) 2017a).

The skills and capabilities of a midwife have been recognised internationally by the International Confederation of Midwives (ICM), World Health Organization (WHO), United Nations (UN) and European Union (EU). The contemporary role of a midwife is defined by the ICM as:

> A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
>
> The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.
>
> A midwife may practise in any setting including the home, community, hospitals, clinics or health units. (ICM 2005)

Globally, midwives share this ICM international definition and practice standards; however, international context influences how this definition is applied to midwifery practice within each country.

The International Confederation of Midwives (ICM) has 132 association member organisations in 113 countries (ICM 2017b). Countries not currently members of the ICM seek membership by demonstrating three key characteristics that demonstrate themselves as a midwifery profession: **recognised specific midwifery education, regulation of practice standards and a professional association** (Day-Stirk and Fauveau 2012). These key characteristics form the three pillars that represent the ICM essential components of professionalism.

The first pillar, recognised specific midwifery education, is guided by the ICM Global Standards for Midwifery Education 2010 (ICM 2013). The Essential Competencies for Basic Midwifery Practice (2010) are used by member states to benchmark curriculum content. The education standards were developed during 2009–2010 using a Delphi survey approach to establish consensus between countries and establish a minimum level of competence as the outcome to direct the core content for any midwifery programme (ICM 2013). Internationally, midwifery students become registered as a midwife after the completion of a programme of study; this may be a direct entry or a post-nursing registration programme. The ICM stipulates minimum time periods for each; direct entry programmes must last a minimum of 3 years, and the post-nursing registration programme lasts for a minimum of 18 months. These education standards provide a minimum acceptable standard; therefore, in practice the scope of midwifery practice varies across continents and between countries, meaning the expectations placed on new midwives at the point of initial registration and subsequent registration renewal vary globally.

Disparity exists in the initial registration standards of new midwives between international countries, and the transition of new graduates to practice is significantly different between countries (Gray et al. 2016a), meaning that qualifications are not directly transferable between comparable westernised countries (Bourgeault et al. 2011). The diversity of global preparation for practice means that midwives in different countries graduate with various levels of autonomy and are prepared for initial registration with variations of the ICM scope of practice.

Regulation of healthcare professional practice is governed by legislation and is enacted by each country to protect the public from those who attempt to provide healthcare services inappropriately (International Confederation of Midwives (ICM) 2011, p.1). In 2002 the ICM adopted a position statement titled ‘Framework for midwifery legislation and regulation’. This position statement defined midwifery legislation and regulation as follows: ‘Midwifery regulation is the set of criteria and processes arising from the legislation that identifies who is a midwife is … The scope of practice is those activities which midwives are educated, competent and authorised to perform … In some countries midwifery practice is regulated through midwifery legislation whilst in others regulation is through nursing legislation …’ (ICM 2011, p.1). Consequently, the scope of midwifery practice is determined by the needs of the country.

The profession of midwifery in developed countries is a product of the economic and political structure of a country and the influence of the professional association bodies and health institutions (Evetts 2003). The third pillar of the ICM sees the importance of member association as a supportive professional network that

represents the interests of the profession and visibly advocates for the midwifery identity through working with governments on policies around standards of care and practice (ICM 2017c).

Midwifery regulation is influenced by the country of practice, as location dictates the scope of midwifery practice activities; for example, rural and remote regions where medical practitioners are scarce means that the scope of the midwife is greater than a midwife in a suburban hospital. In developed countries where midwifery regulation and education standards are established, the legalities of recognition and issues of maintaining or developing autonomy as a separate profession to nursing prevail. For example, in some countries, such as Hong Kong, midwifery as a profession is still not yet recognised or established as a separate profession to nursing (Chap. 6).

The three pillars are recognised as the foundational characteristics of a professional albeit globally each country will enact these foundational elements differently. The initial education of midwives and their transition to practice and ongoing regulation of practice are influenced by the country of origin. Despite the ICM international standards for midwifery education, the outcomes of initial preparation for practice programmes leading to registration have different registration standards and expectations of the new graduate midwife. In countries such as New Zealand and Canada, the new midwife can work in private practice from initial registration, whilst in countries such as the United Kingdom and Australia, new midwives are required to complete a period of practice before being permitted to work autonomously. Differences in legislation, regulation and preparation for practice have been reported even within the same country, as was evident in Australia before national registration occurred (Gray et al. 2016b; Chap. 1: Australia). Such discrepancies impact on the ability of new practitioners to move between countries (Bourgeault et al. 2011); for example, Australian midwives moving to the UK would need to complete a period of time to acquire community practice experience to gain registration with the Nursing and Midwifery Council (Nursing and Midwifery Council 2007).

This book has been prepared to provide readers with the context of midwifery in many international countries. Each chapter has been written by an author knowledgeable and able to inform the reader of the context of midwifery education, practice and regulation in the designated country. This book presents a selection of countries within which midwifery is practiced and midwifery students are prepared for practice. The content will inform the reader of the details of the context within which new midwives in each country transition into qualified practice. Each chapter will describe the legislation of the country, the initial entry to practice education programme/s and regulatory landscape in which midwifery students complete a recognised programme of study and new midwives transition to professional practice as midwives. An outline of how a midwife is educated and gains registration will be explained with details about how transition to qualified practice is organised in each country. Education within each country determines the scope of midwifery practice of all new midwives at point of registration and registration renewal. Starting life as a new midwife will differ depending on the country of graduation.

Regulatory, legislative and educational preparation shapes not only the profession but the maternity services within these countries and the practices of individual midwives. The following countries are included in this book: Australia, Brazil, Belgium, Canada, Ethiopia, Germany, Hong Kong, Iran, Jamaica, New Zealand, the Netherlands and the United Kingdom. Each chapter will provide reflective narratives from new midwives on their lived experience of their first year of practice.

References

Bourgeault IL, Neiterman E, Lebrun J. Midwives on the move: comparing the requirements for practice and integration contexts for internationally educated midwives in Canada with the U.S., U.K. and Australia. Midwifery. 2011;27(3):368–75. doi:10.1016/j.midw.2011.03.010.

Connerton WC. Midwifery. Encyclopaedia Britannica. 2018. https://www.britannica.com/science/midwifery. Accessed 24 July 2018.

Day-Stirk F, Fauveau V. The state of the world's midwifery: making the invisible visible. Int J Gynaecol Obstet. 2012;119(Suppl 1):S39–41. doi:10.1016/j.ijgo.2012.04.003.

Evetts J. The sociological analysis of professionalism. Occupational change in the modern world. Int Sociol. 2003;18:395. doi:10.1177/0268580903018002005.

Gray M, Malott A, Murray B, Sandor C. A scoping review of how new midwifery practitioners transition to practice in Australia, New Zealand, Canada, United Kingdom and The Netherlands. Midwifery. 2016a;42:74–9. doi:10.1016/j.midw.2016.09.018.

Gray M, Rowe J, Barnes M. Midwifery professionalisation and practice: influences of the changed registration standards in Australia. Women Birth. 2016b;29:54–61.

ICM. International definition of the midwife. 2005. http://internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/. Accessed 25 Apr 2018.

ICM. Global standards for midwifery education (2010) amended 2013. 2013. https://internationalmidwives.org/assets/uploads/documents/CoreDocuments/ICM%20Standards%20Guidelines_ammended2013.pdf. Accessed 25 July 2018.

ICM. Annual report 2016 The Hague, The Netherlands. 2017a. https://internationalmidwives.org/assets/uploads/documents/Triennial%20Report/5.2_2016%20ICM%20Annual%20Report_%20EN.pdf. Accessed 25 July 2018.

ICM. Who we are. 2017b. https://internationalmidwives.org/who-we-are/. Accessed 24 July 2018.

ICM. What-we-do. 2017c. https://internationalmidwives.org/what-we-do/association-coredocuments.html. Accessed 25 July 2018.

Nursing and Midwifery Council. Trained outside the EU/EEA. 2007. https://www.nmc.org.uk/registration/joining-the-register/trained-outside-the-eueea/. Accessed 25 July 2018.

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‘Birth of a Midwife: The Transitional Journey from Student to Practitioner’

1

Allison Cummins and Michelle Gray

Abstract

Australia has a mixed private and public health service. The majority of childbearing women will access maternity services through the public health system. The majority of midwives will work as part of the public health system. Most births occur in hospitals attended by a midwife, less than a third of all births occur in a private hospital with an obstetrician, a small proportion occur in a birth centre and <1% occur at home with a privately practising midwife. Midwives are employed to work on a roster in a public or private hospital. Some will work in small group practices providing care to a caseload of women known as midwifery-led continuity of care, usually in the hospital or birth centre setting. An even smaller proportion will provide homebirth as part of the public system or as a privately practising midwife in their own business. Pathways to becoming a midwife include a direct entry undergraduate degree, a direct entry double degree in nursing and midwifery and a postgraduate degree designed for registered nurses. Midwifery is regulated by the Nursing and Midwifery Board of Australia, and all midwives need to be registered with the Australian Health Practitioners Regulation Authority. Newly graduated midwives have traditionally completed a transition to practice program that involves working for a specified period of time in each area of the maternity service. More recently new graduate midwives have been employed directly into midwifery-led continuity of care models. This chapter will provide an overview of the transitional journey from midwifery student to newly graduated midwife in the Australian context.

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1.1 The Australian Midwifery Context

Australia includes a main continent and many islands. The main jurisdictions are divided into eight states and territories: Queensland, New South Wales, Victoria, South Australia, Western Australia, Northern Territory, Tasmania and Australian Capital Territory.

1.1.1 Population

The current population of Australia is 24,524,987 on September 24, 2017, based on the latest United Nations estimates. Australia is home to an equivalent 0.32% of the total world population, with a population density of three people per km^2. The total land area is 7,682,300 km^2 (2,966,151 sq. miles). Despite the large expanse of land, 90.0% of the population live in urban (21,996,082 people in 2017) areas around the edge of the continent. The median age in Australia is 37.5 years (Worldometers 2017) meaning a large reproductive potential. In 2015 according to the Australian Bureau of Statistics, 305,377 babies were born in Australia (ABS population 2017). The infant mortality rate (IMR) in 2015 was the lowest on record at 3.2 infant deaths per 1000 live births. Ten years ago in 2005, the IMR was 4.9 deaths per 1000 live births (Australian Bureau of Statistics 2015). The maternal mortality rate in Australia in 2012–2014 was 6.8 deaths per 100,000 women giving birth, which is among the lowest rates in the world (Australian Institute of Health and Welfare 2017a).

1.2 Australian Political Structure

Australia has a two-tiered government system called the federal and state governments. The federal government is led by a democratically elected prime minister. The federal government is responsible for the national issues such as defence, commerce, currency, trade, air travel, pensions and most social services. The federal government provides funding to the state and territories for many social services including health and education. State and territory governments are led by a democratically elected premier. Each state and territory have designated jurisdictions governed more locally. These local governments are led by a democratically elected mayor and a council who are responsible for local issues such as refuge disposal, pathways and libraries. Terms of office for the prime minister, premiers and mayors are 3 years.

Healthcare is funded by the federal and state governments, and the funding is for a 3-year term in accordance with the elected governments' time in office. The

universal health scheme Medicare is funded by the federal government. Medicare covers all publicly funded medical costs, a percentage of private doctors' fees, optometry and some other medical services but not dental services. The Australian public can also purchase private health insurance that covers additional health expenses that the universal health scheme does not cover. Private healthcare companies sell private healthcare and charge individuals who decide which services they would like to choose.

1.3 Maternity Services Within the Health Service Structure

Australia has a dichotomy of public and private healthcare. Most births (97%) occur in hospitals (73% public and 27% private hospitals) and a small proportion in birth centres (1.8%) and less than 1% give birth at home (Australian Institute of Health and Welfare 2017).

All residents of the Australian population who have access to Medicare are able to use public health services including maternity services at no cost. Around 30% of women choose to use their private health insurance to pay for an obstetrician to lead their care in pregnancy and give birth in a private hospital (Commonwealth of Australia 2009).

As there is limited access to publicly funded homebirth services, women can contract a privately practising midwife to provide care including homebirth (Catling et al. 2014). The cost of this care is covered in part (antenatal and postnatal) by Medicare. Private health insurance has limited to no cover for any private midwifery services. Consequently women wishing to have a homebirth with a privately practising midwife need to fund the care themselves.

The majority of midwives in Australia work within a public- or private-funded hospital. As discussed only a small percentage of midwives provide private care for a woman who employs them for the duration of their childbearing experience usually up to 6 weeks after the birth. Midwives in Australia need to be registered with Australian Health Practitioners Regulation Authority (AHPRA) to practise within a public or private hospital/health setting and require an annotation on the national register to practise as a private practitioner.

1.4 Australian Legislation and Regulation of Midwifery

In Australia all health practitioner practice is governed by legislation (Health Practitioner Regulation National Law Act 2009, Act No. 45 of 2009). The introduction of a national regulatory agency (AHPRA) in 2010 unified the regulation of health professionals under one national board. Fourteen separate health profession boards exist; 1 for each professional body (AHPRA 2011). Each profession has its own national board to govern the initial registration, registration renewal and practice of practitioners. All nurses and midwives are registered with the Australian Health Practitioner Registration Agency (AHPRA 2017) and governed by the same

board: the Nursing and Midwifery Board of Australia (NMBA). The Nursing and Midwifery Board of Australia (NMBA) has the functions of

> registering nursing and midwifery practitioners and students, developing standards, codes and guidelines for the nursing and midwifery profession, handling notifications, complaints, investigations and disciplinary hearings, assessing overseas trained practitioners who wish to practice in Australia and approving accreditation standards and accredited courses of study (NMBA 2015).

Nurses and midwives are registered on separate registers once they have successfully completed a recognised program leading to registration. Each health profession determines the minimum competency standards of practice to be demonstrated for initial registration. In nursing and midwifery, the Australian Nursing and Midwifery Accreditation Council (ANMAC) set the minimum standards to be achieved for initial registration (ANMAC 2014), and the annual registration renewal standards are governed by AHPRA and NMBA (NMBA 2014). Ongoing practice requires practitioners abide by regulatory standards of professional practice. The standards are outlined by the following documents: Code of Professional Conduct for Midwives in Australia (NMBA 2018a), Code of Ethics for Midwives in Australia (NMBA 2018b), *A Midwife's Guide to Professional Boundaries* (NMBA 2010) and the National Competency Standards for the Midwife (NMBA 2006). In 2018, several new updates from reviews mean changes will be made to the existing standards for midwifery practice—from March 1, 2018, there will be a new code of conduct for midwives, and the International Confederation of Midwives (ICM) Code of Ethics (ICM 2008) will replace the current NMBA document. Furthermore, the current National Competency Standards for the Midwife will be replaced by the Midwifery Practice Standards. A date for this change has not been released at this time but is expected in 2018.

The regulation of healthcare practitioners commences when students begin their midwifery education. Under national law all students enrolled in a program approved by AHPRA are entered on the national register. In 2011 the NMBA started to record nursing and midwifery students' details when they commenced training. In 2017 there were 3985 registered midwifery students (Australian Health Practitioner Regulation Agency 2017a). Universities are responsible for sending the NMBA a list of new and continuing students each year (AHPRA Newsletter 2011). Students at university have a criminal history check and a working with children check completed prior to going out on clinical placements and also need an International English Language Test (ELT) result of 7 overall to be registered once they have graduated. There are no fees for student registration, and the register is not publicly available. Anyone with a complaint about a student's conduct must contact the university in the first instance (Australian Health Practitioner Regulation Agency 2018).

1.5 Pathways to Becoming a Midwife

In Australia there are a number of pathways to becoming a midwife. Prospective midwives can complete a direct entry Bachelor of Midwifery program, a double degree in nursing and midwifery or a postgraduate degree in midwifery designed for

registered nurses. All these programs produce graduates who are eligible for registration as a midwife in Australia. Entry to the register as a qualified practitioner requires the completion of a recognised program accredited by the ANMAC (Australian Nursing and Midwifery Accreditation Council 2014). The standards of education programs in Australia are controlled by ANMAC. This national council is made up of nursing and midwifery leaders who establish the benchmarks which programs of study must meet before being able to deliver a curriculum (ANMAC 2014; Australian Government 2014).

Midwifery education programs are provided at a tertiary education level in every state and territory in Australia. Entry to such a program is through state- and territory-based central administration offices where applicants submit an online application demonstrating they meet the requirements of the university they are applying to (University Admissions Centre UAC 2017). Each university sets its own entry requirements which can involve a score awarded from the student's overall position in their peer group based on their exam results from high school. Mature-aged students wishing for a career change or who wish to re-enter the workforce after a long period of absence have a different score awarded based on their education and employment history. Some universities request mature-aged students to complete and pass an entry test or study a preparation for tertiary education pathway which awards a grade at the end of study, which is then used to apply for a place in a degree program.

Traditionally in Australia individuals wishing to become midwives had to gain registration as a nurse first, as midwifery education only existed as a postgraduate nursing qualification. Therefore, Australians who wished to become midwives were expected to complete an undergraduate nursing degree first and then work as a nurse before applying for admission to a hospital and/or university-based post-nursing program in midwifery, usually requiring an additional year of study. Once the midwifery education was completed, nurses were awarded an endorsement or placed on two registers, one for their nursing and one for midwifery depending on the state or territory registration requirements (NNNET 2006). Graduates were then qualified to practise in either profession although you could not register as a midwife without a previous nursing registration. The introduction of the Bachelor of Midwifery programs in 2000 enabled non-nurses to become midwives (Brodie and Barclay 2001).

The Bachelor of Midwifery was introduced in 2002 in Australia after a long collaborative process. The Australian Midwifery Action Project (AMAP) identified the need for radical reforms to midwifery education and regulation in Australia in line with international midwifery education programs and registration standards (Brodie and Barclay 2001; Gray and Smith 2017). The AMAP identified the invisibility of midwifery in Australia, and the group consulted widely with consumer organisations and leaders in maternity services to provide evidence that would influence government agencies, policymakers and professional organisations (Brodie and Barclay 2001). Currently only a limited number of universities offer the program (Australian Health Practitioner Regulation Agency 2017b). Due to the limited

number of places, the course has a high demand, and entry to the program is competitive with applicant numbers far greater than places in the course.

Routes for registered nurses, wishing to become qualified as registered midwives, are offered at undergraduate and postgraduate levels of study. All lead to an entry on the midwifery register. A registered nurse's route to midwifery registration is shorter as the nurse is given credit for prior learning and clinical practice experience. The shortened program varies from university to university but usually lasts 1–2 years. Students wishing to gain qualifications as both a nurse and a midwife on separate registers can opt to study these professions simultaneously in programs designed as a dual bachelor degree that usually takes 4 years.

1.6 Initial Registration as a Midwife

Initial registration to become a registered midwife in Australia requires that midwifery students have a transcript from the university that verifies they have completed a program of study accredited by ANMAC (AHPRA Newsletter 2011). The new graduate completes an online Graduates Application for single registration and sends their transcript from the university to the National Nurses and Midwives Registration Board (NMBA) with a registration fee and proof of identity such as verified birth and marriage certificates (AHPRA 2011). The application process can commence 4–6 weeks before the student has completed their degree in order for all the correct paperwork to be processed by the NMBA (AHPRA Newsletter 2011). This promotes a timely registration once the student's transcript is complete.

It is difficult to know exactly the numbers of graduating midwifery students within Australia. The AHPRA annual report data shows there was an increase in registered midwife registrations between 2015 and 2016 Report and 2016–2017 Report. We can assume that the increases are initial registrations of midwives. In 2017 there were 1843 new midwifery registrants (Australian Health Practitioner Regulation Agency 2017a).

Snapshot of the number of registered midwives in Australia (Data reported in AHPRA annual reports)

2015–2016 AHPRA report	2016/2017 AHPRA report	
RM 4122	RM 6624	Increase 12.2%

Once registered, the midwife can then practise anywhere in Australia due to nationally agreed standards for the learning outcomes from accredited midwifery programs (Australian Nursing and Midwifery Accreditation Council 2014). A new midwife working at level five full time (37.5 h per week) can expect to be paid around $2579.40 for each fortnight and approximately $67,295 per annum. Additional allowances are paid for night duty, working weekends and public holidays. In addition, health service staff are afforded allowances of sick pay, professional development allowances and a pension schemes. Australian midwives can apply for a position in any state or territory and cross borders from where they

originally completed their midwifery degree. Furthermore, they can consider applying for recognition of their qualification in other countries.

An agreement between the Australian and New Zealand national governments in 1992 led to a signed agreement of mutual recognition (Australian Government. Mutual Recognition Act 1992), which enables reciprocal practitioners' agreements between these countries that persist to this day. Nurses and midwives applying for registration in other countries such as the United Kingdom must complete additional education or bridging courses to meet the requirements of that country.

In Australia newly qualified midwives are called new graduates, and they are unable to transition directly into private midwifery practice. The regulatory authority requires a midwife in Australia to have the equivalent of 3-year full-time experience in the full scope of practice before having the option of applying for an endorsement on the register as a Medicare-eligible midwife (Nursing and Midwifery Board of Australia 2017). Recognition in the form of an endorsement/annotation on the national register, of one's ability to practise as a private practice midwife, is granted once the midwife has completed a Midwifery Practice Review process provided by the ACM (Australian College of Midwives 2017). There are three components to the MPR process. Midwives undertaking MPR need to reflect on their practice by writing a synopsis about their knowledge, skills and experience in providing care to women through pregnancy, birth and the postnatal period. The synopsis also needs to demonstrate how the midwife has kept her practice evidence based and current including a learning plan or goal setting for the future. The midwife undertaking MPR then has a meeting with a consumer and an eligible midwife to discuss the midwife's synopsis, reflection on practice and professional development plan. Feedback from the reviewers includes when the midwife will be required to undertake another review, and this is usually after 3 years (Australian College of Midwives 2017). New graduate midwives are unable to apply for an annotation on the register for eligibility until they have completed 3 years of full-time practice; however, a few new graduate midwives have been mentored into Midwifery Group Practice models providing continuity of care (Clements et al. 2012, 2013). The overwhelming majority of new graduate midwives will be employed into a new graduate program designed to support their transition from student to registered midwife.

1.7 Traditional New Graduate Program

Programs designed to ease new midwives into practice are called 'transition to practice program' or 'new graduate program'. In Australia, each state and territory organises their own program that normally lasts for 6–12 months and is a paid position funded by the government (ACT Government ACT Health 2017; Government of Western Australia Department of Health 2017; Northern Territory Government Department of Health 2017; Nursing and Midwifery Office 2017; Queensland Health Clinical Excellence Division 2017; South Australian (SA) Health 2017; Victoria State Government 2017). The support and funding available vary; however,

the programs are remarkably similar with funding allocated to a health service, and then each hospital establishes the number of graduate positions and contractual hours based on the amount of funding available and the number of new graduates.

The process of application for a new graduate position is through a centralised application process through the health department in each state or territory. For example, in New South Wales the application process opens in June and closes in July. The prospective graduate needs to apply online addressing all job criteria and then attend an interview in August for employment to commence in the following February. To be eligible to apply for a graduate position, certain criteria are outlined in each state and territory. Eligibility includes having completed the student's first university undergraduate nursing or midwifery course within the past 2 years, being eligible to apply for registration as a midwife in Australia, meeting the requirements for documentation and identity checks and not having worked as registered nurse or midwife for more than 6 months, full-time equivalent (Nursing and Midwifery Office 2017; Queensland Health Clinical Excellence Division 2017). New graduate program positions are competitive with demand outstripping available positions. The reason for the decline in positions for both nurses and midwives is complex and mostly related to a decline in funding available to most health services (Tuckett et al. 2017). Successful applicants usually begin their program early in the first year after completing their studies.

The new graduate midwife will work in one area of midwifery for a set period of time before rotating to another area. For example, a new graduate midwife is employed on a 12-month contract, and during this period the new graduate will work in the postnatal ward for 3 months then the birthing unit for 6 months and then the antenatal clinic for 3 months. The new graduate programs offer the new graduates support through consolidated study days where they can consolidate knowledge and skills with a facilitator and their peers (Nursing and Midwifery Office 2017).

These types of transition support programs were first established for nurses when the education for nurses moved from the hospital apprenticeship style of learning to the tertiary sector (Evans et al. 2008). Midwifery has traditionally been seen as and treated as a specialty of nursing; thus research into new nursing graduates is relatable to new midwifery graduates. The strengths of the graduate programs are the availability of support for the new graduates through preceptors, clinical nurse educators, study days and peer support. However, it has been reported that the new graduate nurses did not have access to these support mechanisms due to inadequate staffing, and often they were in charge of wards before they were ready (Evans et al. 2008). There is also inconsistency in the length of time of the programs with calls for adequate staffing levels and access to preceptors to improve the programs (Levett-Jones and Firzgerald 2005). More recently a review of the literature found that new graduate programs were successful in retaining nurses; however, the other measured variables were all so different that it was hard to draw conclusions other than offering 'precepting' or mentoring (Rush et al. 2015). The review concluded that healthy work environments that have collegial respectful work relationships decrease reality shock and foster acceptance (Rush et al. 2015). On the contrary many new graduates experience a lack of acceptance and respect with experienced

nurses being insensitive to their needs to develop soft skills such as time management (Rush et al. 2015). Midwifery transitions to practice programs have evolved with similar strengths and weaknesses.

The experiences of new graduate midwives transition to professional practice programs have been reported in a small number of studies. One qualitative study identified the core components of the transition to professional practice program as being placed in one area for 8–16 weeks, having some supernumerary time and having study days and access to a clinical educator (Clements et al. 2012). The problems encountered were related to staffing issues where the new graduate midwives were not offered enough supernumerary time, their rotations were too quick or they were moved to work on another ward leading to feelings of isolation and not being part of the team (Clements et al. 2012). New graduate midwives have reported feeling like they are 'sinking' when working in often understaffed wards with little support from educators (Fenwick et al. 2012). In this study a metaphor of a pond was used, and the new graduate midwives described support from experienced midwives as a 'life raft' (Fenwick et al. 2012). Although these studies were limited to one area health service in one state, they provide insights into what is important to new graduate midwives.

It has been proposed that new graduate midwives who transition directly into midwifery-led continuity of care models will be well supported through the relationship with the small group of midwives they work alongside (Clements et al. 2013; Cummins et al. 2015).

1.8 New Graduate Midwives Working in Midwifery-Led Continuity of Care Models

Midwifery-led continuity of care is defined as care provided to women through pregnancy, birth and the early parenting period by one midwife or a small group of midwives. This model of care is the gold standard of care (Sandall et al. 2016) resulting in less obstetric intervention, less babies born prematurely and higher satisfaction for the woman, all at reduced cost to the health service (McLachlan et al. 2013; Tracy et al. 2013). These findings have led to government recommendations for midwifery-led continuity of care to be expanded throughout Australia. Through this process new graduate midwives have had the opportunity to be employed into the models at the time of graduation (Cummins et al. 2016a).

With the expansion of midwifery models of care, midwives who wish to provide continuity of care are needed to staff the models. Staffing the models has been the main driver to employ new graduate midwives in midwifery-led continuity of care models (Cummins et al. 2016a). The midwifery workforce in Australia is a highly feminised workforce with staff turnover often due to maternity leave (Hartz et al. 2012). This leads to opportunities for new graduates to move into the models during their transitional year.

New graduate midwives report being well prepared to work in midwifery-led continuity of care models through their degree, consolidating skills and knowledge

better when they know the woman and feel supported through the relationship with the small group of midwives they work alongside. As midwifery students need to complete a minimum of ten continuity of care experiences as part of their degree, they are prepared to work in continuity models at the time of graduation (Cummins et al. 2015; Gray et al. 2016). The small group of midwives build trusting relationship with the new graduates and provide support as they are usually available to the new graduates by phone or text at any time of day or night (Cummins et al. 2015). This support is not available in the traditional transition to practice program and demonstrates the benefit of new graduates transitioning straight into continuity of care models. The relationship of trust extends to collaborating with their obstetric colleagues with the new graduates' stating it is easier to discuss a woman's care with an obstetrician when they know the woman (Cummins et al. 2015). The Australian standards for midwifery practice dictate that midwives need to work in collaboration with their obstetric colleagues and other health professionals (Nursing and Midwifery Board of Australia 2006). Evidence-based guidelines have been developed that aid midwives with consultation and referral and enhance collaboration (Australian College of Midwives 2013). Despite these recorded benefits for new graduate midwives and staffing maternity services, there has been resistance to employing new graduates directly into continuity of care models (Cummins et al. 2016a).

In many organisations midwives who wish to work in midwifery-led continuity of care models are required to have at least 12 months experience in midwifery or have completed the transition to professional practice program. This is frustrating for new graduate midwives who feel prepared to work in continuity of care by the nature of their degree. Visionary leaders have been able to manage the myths (Cummins et al. 2016a) that new graduate midwives are not prepared to work in midwifery-led continuity of care and employ them into the models.

A conceptual model has been developed that enables new graduate midwives to work in midwifery-led continuity of care. The model outlines the essential components as building trusting relationships through continuity, providing support including mentoring, preparing students to work in continuity, providing and accessing collaborative team meetings and finally having an approachable manager or clinical support midwife available to support the new graduate (Cummins et al. 2017). The responsibilities for meeting these essential elements are required by both the new graduate and the manager who employs them. Managers who currently employ new graduate midwives provide a longer orientation period and an initial reduced caseload as well as mentors and organise reflective team meetings. This is recommended for all managers who wish to employ new graduate midwives into midwifery-led continuity of care models. New graduates need to seek out continuity of care experiences as students and at the time of graduation. Once in a continuity model, they need to develop professional boundaries, engage in reflective team meetings and seek out a mentor (Cummins et al. 2017). Although this study only had a small number of participants, the sample was drawn from five states and territories in Australia and represented the views of probably half of all new graduates working in midwifery-led continuity of care.

The number of midwives working in midwifery-led continuity of care models remains small as it is estimated that less than 10% of women currently have access to this model of care (Dawson et al. 2016). With government recommendations to expand the models of care (Australian Health Minister's Advisory Council 2016), new graduate midwives will be considered to transition directly into midwifery-led continuity of care models, and they should be supported through well-designed programs such as mentoring.

1.9 Mentorship and Support: Benefits, Challenges, Innovations, Exemplars

Mentoring involves support from a more experienced practitioner (mentor) to a less experienced practitioner (mentee) through a professional relationship. Mentoring traditionally focused on improving job-related skills and career advancement in hierarchical organisation (Eby 1997, 2011). Mentoring has been adopted in many professions including business, nursing and more recently in midwifery.

In the profession of business, the aim of mentoring is to advance the strategic directions of the company (Fajana and Gbajumo-Sheriff 2011). These aims are not dissimilar to the goal of mentoring from within midwifery-led continuity of care models. The midwives who work in midwifery-led continuity of care want to preserve the model for the women as they see it as the best care available. Mentoring new graduates into the midwifery continuity model is seen as protecting the model from being disbanded particularly in times of staff shortages and funding cuts (Cummins et al. 2015). The aims are congruent with those of business to advance the strategic direction and availability of midwifery-led continuity of care models.

In nursing mentoring was originally recommended to assist new graduate nurses to assimilate into the organisation through socialisation and an introduction to the culture of the hospital. It has been proposed nurses would leave the profession if they had not assimilated smoothly by 12 months (Beecroft et al. 2006). As both nursing and midwifery are mostly practised in a hospital setting, there is a need to socialise new graduate midwives, and mentoring has a role to play in retaining staff.

The benefits of mentoring can be summarised as socialisation into the organisation, career advancement and providing an opportunity for role modelling and teaching driven by what the mentee needs to know. Mentoring has been found to increase retention rates of new graduate midwives due to a high level of support (Dixon et al. 2015; McKenna 2003). Although the benefits seem to be far reaching, there are some challenges to providing effective mentorship in midwifery practice.

One of the challenges is the increased workload that the mentor undertakes when they agree to mentoring. Both the business and nursing models recommend training for the mentors and allocated time for the mentors and mentees to meet (Beecroft et al. 2006; Fajana and Gbajumo-Sheriff 2011). Most midwives do not have any formal training in how to provide clinical teaching, and it is difficult to find time to provide mentoring when you are not working alongside the mentee. Mentoring is an emotionally and physically time-consuming activity, and the commitment to