GROUP MENTORING OF NEW GRADUATE MIDWIVES:

EMERGING PROFESSIONAL CAPACITY

A NATURALISTIC INQUIRY

by

Susan Maree Lennox

A thesis submitted to the Victoria University of Wellington

in fulfilment of the

requirements for the degree of

Doctor of Philosophy

in Midwifery

Victoria University of Wellington

2011

ABSTRACT

This research explores an innovative group mentoring model developed at the request of four newly graduated midwives who were mentored as a group by four experienced midwives. Since virtually all research on mentoring, both internationally and in New Zealand assumes that mentoring is a one-to-one activity, this study aimed to describe how this group mentoring model operated and explore whether it was successful in supporting new midwives to gain confidence.

A naturalistic study design was used with a mixed methods approach to collecting and analysing a large amount of richly descriptive data. Data were gathered from records of individual contacts between mentors and new graduates, from a series of interviews with each of the eight participants, and from the actual audio recordings of regular group mentoring meetings across the mentoring year. Simple descriptive analysis of quantitative data and detailed thematic analysis of qualitative data were undertaken.

The study found the group mentoring model provided everything that is expected of one-to-one mentoring and the new graduates felt well supported as they gained confidence during their first year in practice as autonomous self-employed midwives. The group model provided new graduates with 24/7 one-to-one mentor support whenever they asked for it. This was found to occur mostly in the first half of the year and was highly valued.

The new graduates and the mentors all agreed that the most important part of the model were the regular group meetings. These meetings were entirely focused on day to day experiences that the new graduates chose to present to the group. Analysis of the meeting transcripts showed that the new graduates' issues ranged across the whole scope of practice; that they were sometimes prompted by self-reflection, sometimes by issues to do with relationships with others, and sometimes by a need to discuss technical matters. The mentors'

responses were variously supportive; listening and exploring; directing or informing; and questioning or challenging.

The group aspect of this mentoring model added a number of features that would not be possible in one-to-one mentoring. The new graduates valued how the group meetings exposed them to multiple perspectives from several mentors. The group meetings modelled a supportive and collegial way of working together that facilitated their emerging professional capacity now and into their future. The group provided a safe yet challenging space: a "stimulating sanctuary" for the new graduates' development. Overall the study found that group mentoring can successfully meet the needs of new graduates and provides several advantages over one-to-one mentoring. Group mentoring may be a more sustainable model than one-to-one, particularly where there are shortages of mentor midwives available. It is a model that promotes a supportive professional midwife culture, contributes to new knowledge in the area and is the preferred approach to mentoring in the future.

Key words: Midwifery, Mentoring, Group, New graduates, Mixed-methods research

ACKNOWLEDGEMENTS

This year marks 40 years as a midwife for me and this is easily the longest and most desultory labour I have ever been involved with, but at last the baby has emerged. The assistance I have received from my constant and critical companion Professor Maralyn Foureur has been of the highest quality. I have enormous respect and gratitude for your forbearance and champagne, many thanks. There have been a number of academics who were second supervisors and some are also friends: Dr Ismay Barwell, Dr Annemarie Jutel, Dr Margaret Martin, Dr Joan Skinner, and Dr David Stewart. Many thanks for taking your time to listen and share your knowledge and expertise. Thanks also to the Graduate School of Nursing, Midwifery and Health at the Victoria University of Wellington; in particular to Abbey Macdonald, the postgraduate administrator, who has made life easier with her kindness and efficiency.

Outside the birthing room a number of people have patiently waited; thank you dear Evelyn, Gabriela, Gaynor, Hetty, Isabelle, Jennifer, Linda, Milly, Prue, Sandy, Shereen, Stephen and Suzanne your support has been invaluable. A special acknowledgment to the MIHPs; Robyn, Joan, Jeanie and Bronwen for "being there" like good midwives. An enormous sense of gratitude goes to "the group" all of whom shared the challenge with love.

Lastly to my special and precious family; John, Thomas and Alexandra; you were all amazing – thank you to John for many beautifully cooked dinners, walks with Bella and fine milongas, Tom for those early morning Skype sessions from London and YouTube clips which made me laugh when nothing else did, and Alex for lunches, jewellery sessions, and just keeping in regular touch. My other distant but frequent supporters were my brothers Paul, Nicholas and Stuart, my gorgeous cousin Tricia and the one and only, Aunty Valerie.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

I.   BACKGROUND TO MENTORING NEW GRADUATE

MIDWIVES

The support of a mentor has been found to help new graduates in many professions make the transition to autonomous practice (Mills, 2008; Milner & Bossers, 2004; G. Scott & Yates, 2002). In New Zealand midwifery, mentorship is used to build on the technical competence of newly graduated midwives by developing their confidence. Although the most commonly described model of mentorship is a one-to-one relationship between an experienced professional and a neophyte (Yoder, 1990, p. 17), this thesis explores an innovative model where mentoring is provided within a group comprised of both new and experienced midwives.

The study explores the effectiveness of the group model as an alternative way to provide support for new graduates in their first year of practice. I present the argument that this form of group mentoring may have advantages over one-to-one mentoring for new graduate midwives, as well as for their experienced colleagues, the midwifery profession and maternity services in New Zealand and elsewhere.

As background to the study, in this chapter I introduce my experiences and describe the context within which mentorship currently takes place in New Zealand midwifery. This context has been affected by political, legislative, social and professional changes over the last 21 years. The environment within which

the new graduate finds herself[1] is affected by both local and international issues such as; a highly politicised and dominating medico-legal culture of intervention and defensive practices, midwifery workforce shortages, and workplace stress and violence, all of which influence her transition to a confident autonomous practitioner. Mentoring of new graduate midwives was encouraged by the profession in response to these pressures (New Zealand College of Midwives, 1996). I describe how the present group mentoring approach came about and why it was an important area to research. I start by describing my own experiences as midwife, mentee and mentor, because of their importance in understanding the role these experiences have played for me as a participant researcher in this study.

My Mentoring Experience

When I undertook midwifery training, more than three decades ago, I did not intend to become a home birth midwife. My mentorship experience subsequently shaped my professional practice, and directed me towards home births. Although as a student I had witnessed a woman giving birth without the usual pain relief or an episiotomy, it did not shift my medicalised training and orientation toward birth. The woman appeared oblivious to the presence of me and my 20 fellow students, and her baby slipped out effortlessly. While the students were encouraged to think of this woman as rather odd for her refusal of medical help, my subsequent mentor was to help me to see midwifery in a different light.

---

[1] Referring to midwives and the midwife mentors as "she" for ease of expression although it is acknowledged that midwives may be male and female.

Five years later, having seen many medically managed births. I found myself accompanying a home birth midwife in Auckland (New Zealand) and she became my mentor. With her support, I witnessed many more women having straightforward, un-medicated births. I was intrigued by the capacity of these women, who believed that their bodies were quite capable of giving birth without intervention. I recognised, with the help of my mentor, something unique and of great value in their capacity to give birth and care for their babies outside a hospital, with the support of their community of family and friends (Lennox, 2003).

Additionally, my mentor demonstrated a different approach to working with these women and with me. Rather than being "over or above" these women, the midwife worked *with* them and their families (and with me, a midwife with no experience in home birth whom she was mentoring). At the same time, I recognised the value of the subtle mentorship which I had been privileged to receive from her. I accompanied my mentor midwife as she modelled "being with" the women for whom she cared, although I didn't know it at the time, this was an education in mentoring as much as it was in midwifery. This was my first exposure to understanding the value of a midwife being in and belonging to a community.

This mentorship experience constructed a new place for me as a midwife, where being with the women I was attending meant having a relationship between equals. For me, this was both a very new model of providing care as a health professional and a new understanding of midwifery. This meant a fundamental change in my previous relationship to women; I became a knowledgeable witness to birth as a normal life event, active only if warranted.

Women and midwives who shared this understanding of "giving birth by being with" inspired a new model of midwifery in New Zealand. This position does not exclude intervening and challenging, or making tough decisions as a professional when appropriate, alongside respecting a client's personal autonomy. Ultimately, too, mentoring provided a similar approach of "being with" and was the obvious choice of an appropriate approach to professional support for new graduate midwives.

My experience of being mentored reinforced my belief that having an experienced practitioner available and responsive to a newer midwife supports the development of practice confidence in the person being mentored. Since that early experience I have regularly mentored individual midwives for their first year of practice, and have enjoyed the intimate one-to-one relationships that have developed from this activity. These mentoring relationships, though occasionally frustrating, were mostly very satisfying. They were unstructured and individual to each new graduate midwife. In these mentoring relationships I willingly supported the new graduate as she needed but found that, as a busy practitioner, I was often tempted to fall into the trap of telling the new graduate "what to do" rather than listening to her or evoking thinking and feeling responses to practice problems. Additionally, some new graduates want to be told, reinforcing this temptation.

However, being able to gauge whether a mentorship relationship had been successful or met as yet unspecified standards remained tricky. The only measures I had of the success of mentoring were the new graduate's level of satisfaction, and her desire to stay within the profession. I often wondered what could serve as evidence that mentorship had contributed to a change in the

midwife's professional confidence: was it that she contacted her mentor often, or that she was happy to ask anyone's advice, or that she managed well on her own? I wondered whether a successful transition to practice meant that the new midwife would stay in practice for the new graduate year, and whether mentored midwives should be followed up for a longer period of time, such as five years, before proclaiming their successful transition to practice.

In the absence of measurable criteria, I did my best to be someone a new graduate could trust and I was largely satisfied that this meant I was a reasonable mentor. In hindsight, I think that I accepted this approach as "good enough," particularly as the mentoring was voluntary and had no formal structure. I also thought that, since the way I practised was a good model of safe practice and one in which women were very satisfied, I could be confident in considering I was mentoring well, as modelling this was what a new graduate needed from a mentor.

My own experience of being mentored and my continuing interest in the mentoring of new graduate midwives are an integral part of the context for this study since these experiences influenced my approach to the research. But there are also important events within the history of midwifery in New Zealand that need to be considered as part of the context of the study, as well as contributing to its rationale.

The Study's Context

The evolution of midwifery in New Zealand has resulted in particular challenges for the transition of new graduate midwives into autonomous professional

practice, and is therefore relevant when considering suitable models of mentorship for new graduates. A brief overview of this history follows.

Changes to New Zealand midwifery practice in 1990

The 1990 Amendment to the Nurses Act brought changes to the midwifery model of care that reflected a revolution in women's expectations of childbirth and a social change around "right to choose" care options for New Zealand women and midwives (Nurses Amendment Act 1990). The amendment in effect reversed the previous law which required a doctor to be the responsible practitioner at every birth and instead allowed midwives to provide maternity care autonomously. Midwives became entitled to be Lead Maternity Carers (LMCs) though the term LMC was not used until 1996 (Ministry of Health, 1996). Now the woman could choose an LMC, and whoever provided this care – doctor or midwife – was contracted "to provide a woman and her baby with continuity of care throughout pregnancy, labour and birth and the postnatal period" (2002, p. 1044). The law and subsequent changes around payment endorsed publicly funded, autonomous midwifery practice, and enabled a one-to-one midwife-to-woman relationship to emerge as the predominant model of maternity care.

Women were happy with the new one-to-one midwife-to-woman relationship, which inevitably changed the quality and depth of communication between a growing number of women and midwives (Engel, 2000; Schott, 1996). Just as women enjoyed having a meaningful relationship with their carer over the whole of their maternity care, midwives too gained greater work satisfaction from more personalised professional relationships (Ministry of Health, 1999;

Pairman, 1998a). Principles of individual negotiation, equality, shared responsibility and empowerment were valued and informed choice and consent flourished (Guilliland & Pairman, 1995).

The amendment to the Nurses Act (1990) significantly altered midwifery practice for many midwives. Instead of working shifts as hospital employees, many midwives changed to case-loading practices based in the community. Case-loading become shorthand in many Western countries for "continuity of carer" in the community, provided by a primary care midwife. This model stands in contradistinction from "continuity of care", which refers to care provided by a team, called "team midwifery" (C. Homer, Brodie, P., Leap, N., 2008). These are important distinctions to make, since continuity of carer signals a particularly high level of responsibility and accountability for the midwife who will be present throughout the woman's maternity experience. This level of responsibility, whilst having improved the quality of midwifery offered to women, also provides life/work balance challenges for midwives who choose to work as LMCs.

An important feature of LMC midwifery is the variety of work settings in which midwives can operate, but this presents a further challenge to new graduates. The work of the LMC takes place in the hospital *and* in the community, environments that are not usually integrated in other primary care practices in New Zealand. This special feature of the territory of LMC midwifery means that midwives need to understand both environments in order to appreciate and function well across that spectrum. There is international evidence that community work, though more satisfying, is also more stressful than hospital work (Butterworth, Carson, Jeacock, & Clements, 1999).

Providing care in the community has become a cornerstone of midwifery care since the 1990 changes to legislation. Until then, the idea of a community practice was unexplored territory for most midwives. In the year prior to the law change, there were only 50 community-based midwives with hospital access agreements; in the following five years, this number increased to 500 (Guilliland, 1996). The style of practice that evolved during those first five years of autonomous midwifery practice was different from that of the previous community-based practitioners. Those (like myself) who had worked as domiciliary (home birth) midwives before 1990 would have rarely booked as many as four women a month; but by the mid-1990s, following 40 to 50 women a year became accepted as a full-time practice for a case loading, community-based midwife. Community midwifery practice was based on a close one-to-one relationship between each woman and her midwife; especially in the early 1990s. This model was promoted by midwives as a particular reason for choosing midwifery care, rather than the traditional care of a general practitioner obstetrician or specialist obstetrician. Community midwifery practice however required the midwife to be available 24 hours a day, seven days a week (24/7) for a significant number of women. This often resulted in midwives neglecting to take days off or holidays, since they felt that they needed to be available at all times.

New Graduates Enter a Complex Environment

The shakeup of the New Zealand maternity system disrupted the previous social order, where medicine was automatically assumed to be in charge. The disruption has continued on a number of fronts. The following section presents

an account of the complex environment which New Zealand graduates enter in their first year as registered midwives.

At a practice level, hospital midwives and doctors were unprepared for the change and knew little about the government's drive for supporting women's choice of maternity care provider and endorsing midwife autonomy. Many doctors did not welcome the change, and relationships between the medical and midwifery professions deteriorated. When the concept of LMC was introduced, in 1996 (Ministry of Health, 1996), along with the funding and service specifications for all named midwives or doctors responsible for a case-load of women (2002, 2007b), it had significant implications for general practitioner obstetrics. Funding for general practitioner involvement in maternity care was reduced. The eventual consequence of this was that over the next few years nearly all general practitioners ceased providing maternity care, and particularly intra-partum care.

The changes brought conflict within the profession, and concerns were expressed about poor intra-professional relationships. One workforce strategy report commissioned by the District Health Boards of New Zealand (District Health Boards New Zealand, 2006) commented on the need to break down barriers between hospital and self-employed midwives (p.20). Discord was noted too, between recently trained midwives and those who had trained under the previous system (Kensington, 2006; Surtees, 2003). Previously, as in most parts of the world at the time, training for midwifery followed registration as a nurse. Since 1994, direct entry midwifery education has been offered in New Zealand without requiring prior training as a nurse (Surtees, 2008). These new "direct-entry" midwives had a different form of education, with bachelor level university

training and some, but not a great deal, of familiarity with the hospital system. They were able to begin practice in the community under their own authority immediately after they registered.

Alongside the emergence of an autonomous midwifery profession, the other changes have included increasing medicalisation of childbirth (Klein, 2010) and the introduction of consumer rights legislation (The Health and Disability Commissioner Act 1994, 1996), supporting women's choices in childbirth. These changes sit awkwardly alongside one another. Newly registered autonomous midwives are beginning practice in a highly politicised environment with an increasingly anxious community, and escalating rates of intervention in childbirth.

Typically new graduates are passionate about working within their scope of practice (Midwifery Council of New Zealand, 2010) and promoting normal physiological birth in accord with the International Confederation of Midwives (ICM) definition of a midwife (Midwives, 2005). The concept of normal birth is complex (Foureur, 2008) and according to one author "increasingly fragile and subject to formidable challenge" (Crabtree, 2004, p. 96), and that requires "new ways of thinking about woman and birth" (Foureur, 2008, p. 57). Midwives provide care within a highly complex medico-political culture where "what if" conversations make everyone more anxious and can make supporting normal physiology less achievable (Buckley, 2009). There is a growing body of evidence that the environment in which women give birth can alter her physiology and behaviour "…disrupting normal female stress response process during childbirth" (Foureur, 2008, p. 70). Surtees (2008) reflected on the effect of this challenge for midwives: "…paradoxically, they are exhorted to remain the

'guardians of normal birth' in a time of increasing interventions into birth both locally and internationally" (p. 11). Contemporary midwifery practice is accompanied by significant stress which has resulted in many experienced practitioners leaving the profession or intending to do so, according to at least one large workforce study (Wakelin, 2006).

Workforce issues

There were major midwife recruitment and retention problems in New Zealand in 2005, when this study was first discussed. The number of midwives leaving practice had become a concern to health boards throughout the country (District Health Boards New Zealand, 2006). According to the Midwifery Council of New Zealand, the reasons for a "major shortage of midwives in the next few years [were] …a result of [an] aging workforce, changing work patterns and low numbers of new entrants to the profession" (Midwifery Council of New Zealand, 2005, p. 1). After the 1996 changes to the regulations governing maternity providers; particularly those regarding LMC payments, nearly all GPs exited maternity care, increasing the demands on the midwifery workforce (Ministry of Health, 1996). In addition, the midwifery profession had been subject to hostile media coverage after several high profile cases where breech babies had died while in the care of midwives (Macdonald, 2004; Managh, Macdonald, & Andrew, 2004). However, at government level, there was an imperative to maintain a stable midwifery workforce. The government's view was that these deaths were isolated cases and overall the maternity care system was safe and effective, and delivered what women wanted: continuity of carer. Therefore maternity workforce shortages needed to be researched.

The concerns of the Midwifery Council about workforce shortages were echoed in Wakelin's (2006) research, completed 15 years after the legislative changes that enabled autonomous midwifery practice. Wakelin (2006) surveyed all 92 LMC midwives in one region in New Zealand, and reported that 30% of the LMCs studied were planning to leave midwifery within two years, and 54% within five years (p. 87). Many midwives were exhausted by their role. In a situation where the workforce is plentiful, continuity of care is possible and individualised care desirable; but in times of workforce shortages, maintaining work/life balance already challenging for the on-call midwife, becomes more difficult. The midwives in Wakelin's study rated interference with family life and being on call 24/7 as their most difficult issues, and the ones that most contributed to their decision to leave midwifery practice (Wakelin, 2006).

When reflecting on the challenges of being on call 24/7, Miller (2002) urged community-based midwives to: "...acknowledge the complexities around the provision of continuity of care and develop relationships with our midwife partners … [that] support continuity but allow for gaps in continuous care giving" (p.8). Some midwives have heeded Miller's advice and work within a group where their colleagues cover them for days off. When midwives are able to find such backup, there are fewer problems; but when no back up can be found, midwives continue working without even days off, let alone holidays. Evidence from research both in New Zealand and internationally has revealed that the effects of workforce shortages are unsatisfying work for midwives, and unnecessary intervention for women (Curtis, Ball, & Kirkham, 2006b; Wakelin, 2006).

Between 2001 and 2008, the average age of LMC midwives in practice rose from 42 years to 48 years (District Health Boards New Zealand, 2006; Holland, 2001; Pairman, 2008). An aging workforce inevitably means that the already diminishing workforce is further threatened by the loss of midwives through retirement. It also means the loss of mentors able to pass on practice wisdom.

In addition to the workforce problems, the one midwife to one woman practice model, mainstreamed by the 1996 legislative changes, created some real difficulties for midwives. This model, once a choice for a handful of committed domiciliary midwives with small caseloads, was now a highly structured business model that caused exhaustion in experienced midwives and disenchantment in newly qualified direct-entry midwives (Wakelin, 2006).

I was alerted to this problem of disenchantment while working as a volunteer elected to a regional complaints resolution committee and trained in resolving client complaints about midwives. In 2004, a new complaint area emerged when new graduates began to ring in to complain about their midwife mentors leaving them unsupported and in difficult situations. Soon after this experience, I also heard that many new graduate midwives were leaving the profession. After I fielded calls from several disaffected new graduates, the significance of caring for new graduates as well as new mothers captured my attention. Up until then, there had been no workforce shortage. I came to realise that whatever was causing new graduates to leave needed to be addressed for many reasons, including maintaining the midwifery profession as a "public good".

Internationally, midwifery workforce shortfalls are as much a concern as they are in New Zealand, despite differing models of care. In one study on the aging of registered nurses and midwives (these professions are not separated in the international statistics) the proportion of registered nurses and midwives younger than 30 years fell between 1973 and 1998, from 30.3% to 12.1%, and the actual number of working nurses and midwives younger than 30 years decreased by 41% (Buerhaus, Staiger, & Auerbach, 2000, p. 2948). Workforce shortages are an international trend which also applies in New Zealand. In the United States, concerns were expressed about baby boomers retiring in the state of Florida, and academics were encouraged to produce more midwives to replace the increasing number of retirees (Jevitt & Beckstead, 2004, p. 44).

A decreasing number of midwives available for the same or increasing numbers of births limits the ability of midwives to offer continuity of care, help women to achieve undisturbed birth (Buckley, 2009; Foureur, 2008), and provide professional support for new graduates. There was a need therefore to explore new ways of supporting new graduate midwives, but of supporting experienced midwives to provide mentorship which did not rely on the one-to-one 24/7 mentoring model that was commonly being practised.

The Culture of Health Care: Professional Stress and Horizontal Violence

An additional rationale for focusing on the mentorship of new graduate midwives came from a study on stress in the mental health workplace, which showed that the risk of stress lessens with increasing years of experience, but the first year and following five were the most stressful (Humpel & Caputi, 2001, p. 400). These findings fit with studies of the midwifery culture in the United Kingdom,

where significant stress and poor levels of psychosocial health were also found (Sandall, 1997). It was therefore important to focus on the first year in practice.

Further, the issue of workplace bullying – or horizontal violence –not only contributes to midwives leaving the profession, but is also an issue the new graduates would soon have to face. There are many definitions of horizontal violence, some focusing on the acts and intentions of the perpetrator, and others focusing on the effects on the target. One author asserts that "workplace bullying dehumanises people" because "the workplace bully typically uses positional power to identify, undermine, and terminate targets" (Needham, 2003, p. 13). The target suffers "…scapegoating, back-stabbing and negative criticism. The failure to respect privacy or keep confidences, nonverbal innuendo, undermining, lack of openness, unwillingness to help out, and lack of support have all been described as horizontal violence" (Leap, 1997, p. 689). Currently research is focusing on claims that "…the primary impact of bullying is the onset of stress-related diseases and other health complications" (Espel et al., 2009; Namie, 2010). There is evidence that horizontal violence within midwifery has discouraged many midwives from continuing practising both in New Zealand and internationally (Curtis, Ball, & Kirkham, 2006a; Kirkham, 1999; McIver, 2002).

As the midwifery workforce diminishes, many previously unexplored interpersonal and power relationship problems, such as bullying, have risen to the surface and are beginning to be studied. One such study about new graduate nurses showed that New Zealand was no exception to the international evidence about the existence of a culture of horizontal violence (B. McKenna, Smith, Poole, & Coverdale, 2003). Horizontal violence is a significant workplace

problem. According to a recent newspaper article quoting a multicentre study, "Kiwis [are the] worst in the world for bullying" (Mace, 2010). It is therefore unsurprising that research in New Zealand has echoed the international findings that the midwifery culture is one which is swift to blame and punish (Stapleton, Duerden, & Kirkham, 1998).

In one New Zealand study of horizontal violence, eight out of the 12 midwife participants left work and were "…personally and professionally affected by the experience of horizontal violence and consequent bullying behaviour". This experience had "…an important effect on the relationship between midwives, between midwives and women and on the provision of care for women with some of those effects lasting a considerable time" (McIver, 2002, p. 183). The following quotation from a conversation recorded during another New Zealand study describes the effects of horizontal violence on two new graduate midwives, who left the profession as a response to their experiences:

> I'd forgotten, how hierarchical it [hospital] was and how just soul destroying it is and all the personalities you have to deal with day in, day out you know. We really do eat our young...I just used to see it so often; in the tea-room you know everyone was assassinating their colleagues (Kensington, 2005, pp. 146-147).

Workplace bullying is a significant challenge for midwifery, particularly as the capacity for making and maintaining transparent relationships is a core feature of midwifery practice.

Midwifery is a profession where the ability to establish good relationships and make effective judgments is the hallmark of high quality care (Guilliland, 1998; Kirkham & Stapleton, 2000; Pairman, 1998b, 1999, 2006). Flexible responses which form the basis for sound clinical judgement arise out of a trusting environment; so arguably there is a significant risk for women and midwives working within a distrustful culture that engenders rigidity in thinking (Taylor, 1996). The ability to be with women and ably support them is seemingly at odds with the idea that the culture within the profession is characterised by unresponsive and uncaring attitudes. However, research suggests this paradoxical behaviour is to some extent a reality (Kensington, 2005; S. Stewart & Wootton, 2005b). The lack of support within midwifery culture means that midwives feel discouraged and leave the profession. This attrition diminishes the workforce and further increases the pressure on the remaining practitioners. Therefore, setting up and researching innovative and sustainable approaches to supporting newly registered midwives, without adding to workforce stress, may provide important new insights into how to manage these issues.

The State of Midwifery Mentoring

At the time this study began, mentoring of new graduate midwives in New Zealand was an ad hoc voluntary activity taken on by experienced midwives, generally at the request of the new graduate. The government did not pay mentors and if there was a payment at all, it was negotiated between the individual mentor and the new graduate. When surveyed in 2005 about the role of the mentor, midwives showed confusion about the concept of mentoring (S. Stewart & Wootton, 2005b). A large percentage (84%) saw mentoring as face-to-

face contact in the clinical setting; almost as many (81%) believed that the responsibility of the mentor midwife was to provide hands-on clinical support (S. Stewart & Wootton, 2005b, p. 33). The report on mentoring concluded that "… [in] New Zealand the application of mentoring appears to be a mixture of supervision, preceptorship and mentorship" (S. Stewart & Wootton, 2005b, p. 5).

This confusion has abated with the introduction in 2007 of the government funded Midwifery First Year of Practice (MFYP) programme (Ministry of Health, 2007a). The Ministry of Health was obviously just as concerned as those in the profession who were aware of the workforce issues. In an evaluation of what was then a pilot First Year in Practice programme, the reason given for the government funding was resoundingly "in response to midwifery workforce issues identified by the profession and the Ministry" (Oliver, 2008, p. 1). The mentoring component of the programme was identified by the evaluator as supporting "considerable increases in confidence, knowledge and safety, together with good job satisfaction" for the new graduates (Oliver, 2008, p. 4). However, despite this very positive evaluation and the fact that "77% of graduate survey respondents indicated a strong likelihood of remaining in the workforce", a large "23% indicated a degree of uncertainty and three indicated they were not confident they would remain" (2008). There is clearly much entailed in maintaining a satisfied workforce, and mentoring is only one component of ensuring new graduate retention, according to the evaluation. The present study of group mentoring took place in 2006, a year prior to the government funded MFYP scheme; it therefore took place at a time when, as a result of workforce shortages, one-to-one mentors were unavailable for soon-to-be registered midwives.

The Search for Mentors

Late in 2005, the plight of students (soon to be midwives) having difficulty in finding mentors was presented to a regional New Zealand College of Midwives (NZCOM) meeting as a critical professional issue that needed to be considered by the membership and a solution found. I was one of a group of four experienced, busy, midwives attending the meeting who felt compelled to ensure that the students received appropriate support when beginning their first year of clinical practice. We met and discussed the challenges of mentors having to be on call 24/7 for each mentored midwife, a commitment which none of the four of us could individually make. The idea of a group mentoring was discussed between the four soon-to-be new graduates and the four experienced midwives; all eight agreed that the experienced midwives would share the mentoring of the new graduates in a group-mentoring project. After much deliberation, the group of eight designed a model of group mentorship which distributed the role of mentor amongst the four experienced midwives.

Setting Up the Relationship

The mentorship group was comprised of four experienced midwives and four new graduate midwives. The mentorship group began in September 2005, prior to the new midwives' graduation, and ended in December 2006, when their first year in practice was completed. The four new midwives graduated with a Bachelor of Midwifery degree from a tertiary institution in a major New Zealand city. All were aged between 23 and 45 years. The four experienced midwives each had more than 20 years of experience in a range of clinical settings (home, primary birth units, regional and tertiary level hospitals). Two were full-time

university academics with doctoral degrees and part-time clinical practice caseloads, and two were doctoral students and part-time clinicians with lecturing roles. They were aged between 50 and 59 years.

At the outset of the project, the eight participants met to clarify the expectations of mentorship and the structure of the mentoring process. The students specified what they wanted from mentoring which centred on being in charge of when and if they called the mentor(s) for support and to establish what support was possible. They came prepared with a list of their expectations, including:

- mentors to be physically present for the first time for every new experience such as induction of labour

- mentors to be available for advice 24 hours a day, seven days a week

- mentors to be available to provide support and encouragement when the new graduates felt despondent

- mentors to be available for debriefing, reflection and feedback

- mentors to assist with information about supplies needed for setting up in practice

- mentors to proactively offer advice and tips (Lennox, 2005, p. 5)

The mentors and students negotiated the structure of the process initially verbally, and subsequently this became a signed contract in May 2006 (Appendix A). The structure of the group mentorship model was based on a mentor being accessible 24/7 by phone or in person for the new graduate midwives' first year in practice. A roster was created where one mentor midwife (one mentor on-call

for one week) would always be available for any calls for assistance from the new graduates. Each week, a meeting of the group (mentors and new graduates) was scheduled.

Reasons for Studying the Mentoring of New Graduate Midwives

Beyond the practical need for mentoring created by workforce shortages and professional stress described above, there is also a need to better understand how midwives with experience pass on what they know (Anderson & Pearson, 1999). The process of passing on practice wisdom to new midwife practitioners is under-researched. This study provides an opportunity to explore how, if at all, such embodied knowledge can be passed on in a group setting.

Practice wisdom is a complex knowing, entailing an integration of both the sciences and the arts. This integration of knowledge is unconsciously acquired and embodied through the experience of being in practice. For this knowledge to become conscious a process of regular reflection is necessary; regular reflection allows one to develop the capacity for critical appraisal. Without this process of reflection and critical appraisal, the practitioner's knowledge or practice wisdom will remain unconscious. The practitioners who rely on habits of practice behaviour that have become routine will lack a nuanced understanding of why they acted in a certain way. This does not necessarily make the practitioners' behaviours unsafe, but it does greatly diminish their ability to pass on practice wisdom to students and new practitioners. The quality of critique about practice by practising midwives has a bearing on how they practise and how they mentor.

Critiquing practice is something I am called upon to do regularly. As an expert witness and clinical advisor, I provide advice related to complaints about midwives to a variety of regulatory bodies, such as the New Zealand Accident Compensation Corporation (ACC), the Office of the Coroner and, in the recent past to the Health and Disabilities Commissioner (H&DC) and the Health Practitioners Disciplinary Tribunal. This work has provided me with a particular lens on midwifery standards, and has highlighted the need to develop confident, well-informed midwifery practitioners. Such practitioners are well able to articulate their thinking in and about practice, despite the risk-averse culture within which they work. Hence when the opportunity arose to undertake a group mentorship project, I realised the potential for studying the process of developing well-informed midwife practitioners in action via a novel model, which, if successful, might alleviate many of the difficulties presented by the context in which midwifery mentoring currently takes place.

This study therefore seeks to contribute to knowledge about group mentoring, about the new graduate's satisfaction with her working world, and about group mentoring as an alternative means of passing on practice wisdom and developing an ability to reflect on and critique practice, both one's own and others'. Such a group process may also enhance workforce recruitment and retention and improve the safety of maternity care. This research will contribute to an international understanding of how this group mentorship process of knowledge-sharing is created, enhanced and fostered to support best practice.

Aims of the Research

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.

I seek to fully describe the group mentorship model, using a descriptive approach based on data gathered from interviews with new graduates and mentors, logs of contacts between new graduates and mentors, data about the births the new graduates attended, and analysis of recordings of the weekly group meetings between new graduates and mentors. In the chapters which follow, I present this study's underpinning framework, methods, findings and implications.

The Structure of this Thesis

In Chapter Two**,** I present a historical overview of the concept of mentoring, and of its emergence and development in the twentieth century. This exploration includes investigating the concept that two persons, a mentor and a protégé, are the necessary antecedents for professional support to be considered "mentoring". This one-to-one theory of mentoring is challenged throughout this thesis but particularly in Chapter Two. Mentoring is used for professional support at all levels of practice, whether for leadership, minority groups, undergraduates or new graduates, but this survey of the literature is concerned only with new graduates. There are two models of mentoring in the literature: developmental

and sponsorship. Briefly, the partner who is in charge of the type and frequency of interactions between the mentor and the mentee defines which model is in use (Clutterbuck, 2009). If it is a developmental model the mentee is in charge of the types and frequency of the interactions and if it is the sponsorship model the mentor is in charge of the types and frequency of interactions. These two models are used to highlight the differences between the types of relationship and the objectives of the relationship in this and other research studies. In the new graduate literature, descriptions generally categorise new graduates in terms of their deficiency, an analysis which is disputed in this research. There is little research on new graduates receiving professional support in a situation where they are active partners within a peer support group. The mentoring research in this study is derived from a project which used a developmental model of professional peer support for new graduate midwives.

Chapter Three outlines the study design and provides a theoretical justification for a naturalistic study of group mentoring of new graduates. A range of research design approaches were considered and critiqued in relation to the study design. These will be discussed in order to provide a justification for the final decision to utilise a pragmatic, exploratory, descriptive framework. The study therefore sits under the umbrella of a pragmatic paradigm which connects theory to practice, using mixed methods. Named methodologies such as participant action research, ethnographic research and mixed methodology research are explored and rejected as over-claiming and inappropriate. However a mixed methods approach to data collection was undertaken as this was a unique opportunity to explore various dimensions of new graduate mentoring. Two processes of data analysis were used, one for the background data, and another

for the transcripts and tapes of the mentoring meetings. These transcripts and tapes became the main focus of the study. The design chapter closes with a thorough review of the study's ethical concerns, and the rigour and trustworthiness of the study, and finally presents the researcher's reflexive account of her role in the study.

Chapter Four describes the findings of the study, using a descriptive and thematic analysis of all the data collected, apart from the meeting transcripts (logs of contacts, interviews with new graduates, including scores of confidence, and mentor interviews). The initial questions asked of this study covered a range of the interests in the field of first year of practice research and these provided direction for the data collection. These data now serve as a sounding board for developing a "view" about mentoring from the inside of a mentoring project.

Chapter Five presents the findings from thematic analysis of transcripts of recordings of mentoring meetings. These transcripts represent a unique perspective on mentoring in midwifery. Mentoring meetings between experienced and new graduate midwives have not previously been recorded and analysed. The findings throw light on what are the sorts of issues for which new graduates choose to seek mentor support, and how the mentors respond.

Chapter Six concludes the thesis with a discussion about group mentoring new midwives in their first year in practice, based on the findings from the various sources of data. It highlights what the new graduates found most helpful in terms of mentoring, the differences in perspectives and professional values which emerged between mentors at meetings, and how these differences were viewed by the new graduates. The chapter also provides a critical examination of

the limitations of the study, its strengths, and its contribution to midwifery knowledge.

Summary

This first chapter has explained that the inspiration for the group mentoring approach which formed the basis for this study was a response by four experienced midwives to the needs of a group of new graduate midwives. As a researcher, I saw this as an opportunity to explore an approach that had not previously been described or analysed. This opportunity was the logical extension of my own experience of mentoring and being mentored, but also a reasonable response to the workforce imperatives emerging from New Zealand's system of autonomous midwifery practice. New midwives must adapt to a system where there are considerable demands on them and where they face inter- and intra-professional pressures. The chapter also outlined the significant contemporary pressures on the midwifery profession, and the need to understand how midwifery wisdom can be effectively passed on to new graduates through mentoring processes. In the next chapter, I describe previous research on mentoring, on new graduates and on group mentoring.

II.   GROUP MENTORING OF NEW GRADUATES: REVIEWING

THE LITERATURE

This chapter presents a critical review of the international research literature on the meaning and models of mentoring, how new graduates are perceived, and group approaches to mentoring. The aim in undertaking this review was to examine what is meant by mentoring and how the topic has been investigated by other researchers. This aim was both to increase my understanding of mentoring, and also to inform decisions on how my study of a group mentoring model should be constructed, what particular questions needed to be asked, and what forms of data needed to be collected and analysed. Because a group mentoring approach has previously been untried in New Zealand midwifery, I was most interested to discover where and how group mentorship might have been previously investigated, and how it might have been compared with the traditional one-to-one model.

My search of the literature was undertaken initially in 2006, and then each year up until 2010. However, very little research literature was found on mentorship located within midwifery, or mentoring new graduates within any professional group, or indeed group mentorship generally. On the other hand, there is considerable research and reflections from a number of disciplines which is highly relevant to the current study, and served to increase my understanding of mentoring. This chapter describes the search strategies used and then considers the relevant literature in three areas: mentoring and other career development relationships, the needs of new graduates, and group mentoring.

Search Strategies and Terms Used.

In 2006 I explored the literature for the years 1999 to 2005 via the Cinahl, Cochrane, Proquest, and Medline databases. I searched for the terms mentor* or preceptor*, along with nurs* or midwife*, and found 1,200 items. The great majority were non-research articles about student nursing education. When I refined the search to English language research articles only I found 69 references. I used the term "preceptor" because typically this was the term used for professional support in the new graduate year of nursing in the UK (Andrews & Wallis, 1999). The term "preceptor" is also often the term used in Australia, Canada and the US to describe professional support in the new graduate year. The use of "nursing" as well as midwifery in the searches became standard both because of the dearth of midwifery-specific research, and because nursing often includes midwifery. Additional material was located by hand searching journals and reviewing the reference lists of articles and relevant texts. A data search in April 2008 in Proquest and Cinahl for the key words "group mentoring" turned up one only reference in Proquest and none in Cinahl.

There has been more research carried out in the last four years on supporting new graduates. A 2010 search in Cinahl for research articles on midw* or nurs*, and mentor* or preceptor*, and "new graduate" yielded 132 references. Excluding articles referring to student* reduced the yield to 81 articles. Articles about students were excluded because mentoring of undergraduates is quite different (e.g. it includes assessment) from mentoring of registered and fully accountable new graduates.

Group mentoring is a much less well-established process than the more traditional one-to-one mentoring. For example, a Google search on the term "mentoring" returns 14 million results, whereas "group mentoring" returns only 40,000. There is little relevant academic research on group mentoring. Searching for academic journal, English language articles with abstracts using the term "group mentoring" yielded 22 articles on ISI Web of Knowledge databases, 28 on Proquest, and 11 on Cinahl with many of the articles appearing in more than one of the searches. Hand searching within these results yielded 10 useful articles, after excluding those which were not about professional development (some, for example, were about mentoring youth or disadvantaged people), or were about students or peer mentoring. These 10 articles are reviewed in the third part of this chapter concerning group mentorship models. I begin by exploring the relevant history of the concept of mentoring, to reveal the traditional understanding of an intimate one-to-one relationship.

Mentoring – What It Is and How It Has Developed

This section looks at what the literature says about mentoring – where it arose, what it means, and its key functions and attributes. This is particularly important in terms of measuring the innovative group approach against traditional models.

Historical Roots

Mentoring initially emerged in the twentieth century as a one-to-one relationship for career development, based on friendship between an experienced individual and a novice within the business world. This friendship was likened to the roles played by Homer's two characters in *The Odyssey* when Odysseus went off to

war, Mentor, a close friend of Odysseus, willingly took over the role of father for Telemarchus, Odysseus' baby son (Homer, 1945). Later when Telemarchus was a young adult he was visited by the goddess Pallas Athena, disguised as a chieftain called Mentes who came to "embolden" Telemarchus (1945, p. 23). There are echoes of this undertaking too in the modern interpretation of mentoring between adults. Athena was closely associated with the owl, a symbol of wisdom and appropriate for the role of a mentor (Clutterbuck, 2009, p. 16). However tales associated with the role of mentor as wise counsellor may act as a caution: "Yet they [mentors] are only the embodiment of wisdom, never the source. This is a particularly important distinction, one too often forgotten by overly dependent travelers and easily flattered guides" (Daloz, 1986, p. 30). The mentoring relationship, with its archetypal roots, was officially rediscovered by business practitioners in the 1960s, and since then has been developed and reshaped.

Modern mentoring is located as beginning as an informal relationship within business circles, where the executive or head of a company saw potential in a young graduate and went out of his[2] way to support and promote (sponsor) that individual. The subsequent development of practices led to research that associated corporate career success with supportive working relationships, and labelled the activity "mentoring" (E. G. C. Collins & Scott, 1978; Kram, 1983). In the last third of the twentieth century, a significant body of research provided evidence of the value of mentoring to later career success (Berlew & Douglas,

---

[2] The male gender term is used here because modern mentoring was defined as a predominantly male activity.

1966; Dalton, Thompson, & Price, 1977; Kram, 1983, 1985, 1988; Levinson, Darrow, Klein, Levinson, & McKee, 1978).

Although mentoring was initially practised within US business communities in the 1960s and 1970s, it was soon taken up by the education and health professions in all western countries (Hall, 1998; Smith, Basmasjian, Kirell, & Koziol, 2003; Vance, 1977). In the late 1970s and 1980s, feminism also gave support to women developing their careers, and mentoring provided the impetus for them to achieve career success (Roche, 1979; Shapiro, Haseltine, & Rowe, 1978). Although mentoring was provided for new graduate males in the business world, it was in mid-career management that women first had mentoring offered to them. One such woman was Vance (1977), a leader in nursing who studied the success of patronage for the best and the brightest. She encouraged experienced nurse leaders to use their "…positions, connections, resources and influence to guide and promote some promising persons" (Vance, 1982, p. 12). Vance believed that "helping and being helped by each other" encouraged mentoring relationships amongst nurse leaders, enabling them to become "more powerful in their personal and work lives" (1982, p. 7). Vance identified mentoring as useful for women in leadership, but also envisioned a time when this support could be more universally available, and "evolve into some form of institutional support in many organizations" (p. 7).

Internationally, mentoring has been the term used for providing formal support to undergraduates (Finnerty, 2005; McVeigh, Ford, O'Donnell, Rushby, & Squance, 2009; Watson, 1999; Wrightson, 2001) or for encouraging leadership or supporting minority or "outsider" groups within the professions (Powell-Kennedy, Erickson-Owens, & Davis, 2006). Vance's encouragement to nurses

suggests that both the mentor and the mentee gain from the experience of mentoring which may give some credence to the notion that the female developmental journey "emphasize[s] connection and care rather than isolation and hierarchy" where the latter is understood as a male developmental task (Daloz, 1986, p. 26). The rediscovery of mentoring and its ability to support individuals seems well recognised; how mentoring is enacted may vary, but whether this entails gender specific developmental tasks is outside the scope of this study. However, it would be interesting to look for evidence of "connection and care" in this study. What is meant by mentoring internationally will be considered next before looking to how it is defined in this study.

Definitions of Mentoring and Other Similar Developmental Relationships

Clutterbuck (2004) claims that unless research identifies the "type of relationship and the objectives of the relationship, it is likely to be misguided and probably misleading" (Clutterbuck, 2004, p. 12). Mentoring and other terms which come under the rubric of a career development relationship, such as preceptoring and clinical supervision, do not have universally agreed definitions (Hays, Gerber, & Minichiello, 1999; Rodgers, 1989; B. M. Stewart & Kreuger, 1996; Yoder, 1990). In New Zealand midwifery, mentoring has been identified as the appropriate professional support relationship for all registered midwives, though it has most commonly been used to support new graduates (New Zealand College of Midwives, 1996). The New Zealand College of Midwives (NZCOM) consensus statement on mentoring begins with the following definitional statement:

The mentoring relationship is one of negotiated partnership between two registered midwives. Its purpose is to enable and develop professional confidence. Its duration and structure is mutually defined and agreed by each partner.

A mentor listens, challenges, supports and guides another midwife's work. A mentor does not always give answers but encourages the mentored midwife to research, explore and reflect on her practice.

The mentored midwife remains responsible and accountable for her own practice in accordance with statutory obligations of a registered midwife. (New Zealand College of Midwives, 2000)

This statement appears to be modelled on a negotiated relationship similar to those of the one-to-one partnership between a midwife and her client (Guilliland, 1998; Guilliland & Pairman, 1995; New Zealand College of Midwives, 2000). The principles within this "midwifery partnership" are individual negotiation, equality, shared responsibility and empowerment, and informed choice and consent (Guilliland & Pairman, 2010, p. 41). The tone of the NZCOM consensus statement on mentoring (Appendix B) echoes similar values to the mentoring partnership values, with the onus being on the individuals to take responsibility for negotiating the structure of their mentoring relationship. The stated purpose of mentoring in the NZCOM consensus statement on mentoring is "to enable and develop professional confidence"; this indicates that the model of mentoring being encouraged is a developmental one, with a focus on the mentee (New Zealand College of Midwives, 2000), and see the section below on sponsorship and developmental models of mentoring (p. 41).

The NZCOM consensus statement on mentoring is less formal than the definition given in the New Zealand Government's Midwifery First Year of Practice (MFYP) programme, begun in 2007, which describes mentoring as "a supportive and educational relationship intended to provide role modelling, clinical support and development, and socialisation into the work environment" (Ministry, 2009).

In this thesis, mentoring is defined as "a voluntarily agreed professional support activity in which the person being mentored is the active partner, their needs are the focus of the mentoring, and the mentor intention is to assist and cultivate their professional confidence". Meeting the new graduates' needs by ensuring the new graduates take the active role defines the type of mentoring relationship established between the new graduates and the mentors in the group mentoring being studied here. In such a relationship, the "less experienced person (mentee) aims to gain knowledge, develop skills, and achieve insights with the help of the more experienced person (mentor)" (Clark, 2004, p. 7). The purpose of the relationship is to develop new graduate confidence, a purpose which is in line with the NZCOM consensus statement on mentoring (New Zealand College of Midwives, 2000).

Titles, Practices and Places Alter Meaning

The professional practices called mentoring, preceptoring and supervision vary in their meaning and usage from time to time and place to place, and they may or may not bear much resemblance to another practice of the same name elsewhere (Kram, 1983, p. 609). Internationally, terms, titles and concepts vary in their definitions and understandings "on the ground"; this is an important feature of

trying to make sense of the terms. In order to understand the research, it is important to differentiate mentoring from other career development relationships; however, this task is difficult, because all three relationships share some of the same functions. All three are what have been called "enabling relationships" with core characteristics such as encouraging the learner to "set their own agenda", being an "effective role model", providing opportunities for "critical reflection", reinforcing "individual's strengths," discussing "successes and failures" and "offering constructive feedback" (Morton-Cooper & Palmer, 2005(b), pp. 188-189). I would argue there are many examples where such core characteristics are not shared; and one which deserves special mention is the statutory supervision of midwives in Britain, which was instituted in 1902 and whose core characteristics are not seen as enabling. This legislation was initially aimed at control of midwives who were in the main practising independently (Kirkham, 1996). There are according to Kirkham "contradictions inherent in the very role of supervisor of midwives" (1996, p. 1). The contradictions include a supervisor both policing and facilitating practicing midwives; protecting the public by preventing poor practice and empowering the midwife by facilitating good practice (p. 3). The argument about role contradiction for some midwives turns on who has power in the relationship. The Midwives Rules (UK 1993, rule 44, p.22) shows that the supervisor of midwives is appointed to be "over" the midwife rather than "with" the midwife (Deery & Corby, 1996, p. 206). Therefore arguments are made for the value of clinical supervision, as well as that of the role of supervisor of midwives, on the grounds that the latter exists in an environment where a safe relationship with the supervisee is not possible. They argue that a "…safe relationship [is] required for clinical supervision [and

that this] is threatened by the supervisor and hierarchical nature of the supervisor of midwives role" (Deery & Corby, 1996, p. 206). Clinical supervision in this thesis refers to an off-line, client chosen supervisor who has a facilitative role rather than a policing one. Therefore the attributes of any terms used in career development relationships need close attention.

The critical attributes of preceptorship, clinical supervision and mentorship may throw some light on the differences. Preceptorship is the easiest of the three to separate from the other two systems of professional support, because it is an appointed position and the functions are more prescribed. Preceptorship is of a shorter duration than the other two (weeks rather than months); moreover the role is about assessing the preceptees' fitness to practise, and it therefore entails skills assessment and serves to socialise the preceptee into a hospital environment. In the other two roles, the off-line (i.e. not holding an up-line management position) clinical supervisor or mentor encourages critical reflection, the person is typically chosen by the mentee or supervisee, no formal assessment is entailed, and the duration of the relationship is longer than that of preceptorship. Clinical supervision is more often sought outside a particular occupational group, and is commonly mandated by a particular profession, such as social work, psychology, psychotherapy or counselling, where skilled communication is a core competency.

Mentoring, by contrast, is often associated with a professional role transition, where the person with experience in that role is the mentor. In this situation the mentee may be as experienced in the work as the mentor, but the mentor may have particular local knowledge unknown to the mentee; for example, the mentee might be a new immigrant or might be starting in a new

position such as core staff midwife, when their previous experience has been in LMC work only. The context for the three roles is generally different, though they are all career development relationships. Table 1 summarises the most commonly held assumptions, similarities and differences for each of the terms – though contrary examples exist for each of the categories. This study will make use of the outlined features of mentoring when evaluating group mentoring. The functions that mentoring serves have been extensively researched and are discussed in the next section.

Table 1: Broad differences between mentoring, preceptoring and clinical supervision (Lennox, Skinner, & Foureur, 2008)

Feature	Mentoring	Preceptoring	Clinical Supervision
Duration	Long term commitment. (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Firtko, Stewart, & Knox, 2005)	Short term commitment. (Firtko, et al., 2005)	Variable and dependent on supervisee. Tends to be ongoing.
Choice of supporter	Mentee chooses mentor. A voluntary relationship between registered professionals where the inexperienced or novice practitioner chooses the experienced practitioner as an appropriate guide through a process of attaining confidence.	Preceptor appointed not chosen. Preceptoring differs conceptually from mentoring particularly in regard to the preceptor being allocated to, rather than chosen by, the new graduate.	Chosen in independent supervision: a relationship which has no formal assessment or managerial oversight. (Other types of "supervision" differ)
Purpose	Enable or develop professional confidence. A mentoring relationship is one of supporting professional transition through new environments and/or experiences. This relationship may not be established or maintained by an employer.	Fitness to practise; clinical development. The preceptor role is described differently to mentoring focusing on the content to be covered rather than on the new graduate's experience of practice.	Process of reflective self-assessment may include both high support and high challenge. (Johns & Freshwater, 1998)
Beginning	Negotiated between the parties.	Ascribed.	Negotiated.
Ending	By mutual and negotiated consent.	Preceptorship term finishes, after one or two weeks or up to a couple of months.	Ends when supervisee decides.
Reason for Government support	Response to workforce concerns both at the recruitment and the retention ends. Transition to practice is one of the key concepts attached to mentoring. (Passant, 2002; Theobald, 2002)	Response to reality shock in UK and US. Support transition; role mastery and socialisation.	Change from task orientation to nursing process and professional governance.

Mentoring Functions

Kram (1983), a business management researcher, was the first to write about the functions of mentoring. She studied 18 mentoring relationships in business settings, using intense biographical interviews to establish the functions of mentoring and determine the phases of the mentoring relationship (1983, p. 608). The analysis showed nine mentoring functions divided into two dimensions: functions that were *instrumental* in advancing the protégé's career, and functions that were concerned with *psychosocial issues*. The use of the term "protégé" here is intentional, and literally means "a person who is protected and aided by the patronage of another", indicating a particular type of mentoring relationship (Collins, 1990, p. 796). The instrumental or career functions included sponsorship (the mentor overtly encourages the career development of the protégé); exposure and visibility (the protégé is shown in a good light); coaching (acknowledgment of protégé's competence); protection (the mentor shields the protégé from criticism); and challenging assignments (the mentor creates learning and development opportunities). The psychosocial functions included role modelling (the mentor as good role example); acceptance and confirmation (non-judgemental regard); counselling (listening and reflecting); and friendship (kindness). Kram provides an analysis of the relationship and a benchmark for mentoring which has informed many other studies as well as the present group mentoring study. Table 2 sets out these functions in the two dimensions.

Table 2: Mentoring Functions (Kram, 1983, p. 614)

Instrumental/Career Functions	Psychosocial Functions
Sponsorship	Role Modelling
Exposure and visibility	Acceptance and confirmation
Coaching	Counselling
Protection	Friendship
Challenging assignments	

Yoder, a nurse researcher (1990, p. 17), presented a concept analysis of mentoring across the disciplines of business, education and nursing, using Kram's functions as her model. She emphasised the importance of an inter-personal relationship between mentor and protégé over an extended period of time. She cited a definition of mentoring by Bowen (1985) which emphasised that "if the opportunity presents itself, the mentor also uses both formal and informal forms of influence to further the career of the protégé" (p. 13). It is this use of influence by the mentor which has led some researchers and writers to distinguish between what they have called the "sponsorship model" and the "developmental model" (Clutterbuck, 2009). These terms distinguish how power in the relationship is managed. For example, in the present study of mentoring the new graduates (mentees) had an "active role" in negotiating the relationship, and the mentors who were the "responders" voluntarily "parked" their power to support the new graduates in their growth to professional confidence. The mentoring model being used was therefore a developmental model rather than a sponsorship model.

Comparing Sponsorship and Developmental Models of Mentoring

Although the functions offer a broad evaluative framework for reviewing mentoring, fully understanding the differences between these models of mentoring is also important. Clutterbuck referred to the sort of mentoring where the mentor uses forms of influence or applied power as the sponsorship model of or approach to mentoring. He notes that this sponsorship approach to mentoring is more commonly accepted in US culture than in British, Australian, New Zealand or Canadian cultures, where the developmental model or approach is more acceptable (Clutterbuck, 2009, p. 12). "Essentially, one [developmental] emphasises empowerment and personal accountability; the other [sponsorship] the effective use of power and influence" (Clutterbuck, 2009, p. 19).

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 plans and processes to achieving this end are purposely put in place by mutual dialogue and negotiation. Both parties are engaged in the process of achieving this end, without the mentor using her institutional influence to privilege the mentee. The purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of the role. 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. The basis for an end to the mentoring relationship is decided at the beginning, and can therefore be openly discussed at any point in the relationship.

By contrast, in the sponsorship model the protégé is chosen by the mentor, who uses her power to benefit the career progress of her protégé. The mentor is the active partner and advises the protégé about what she believes is important. The protégé receives the benefits of her mentor's power, and their relationship is built on gratitude for the benefits (advice and introductions) which are bestowed rather than achieved. The mentee generally grows out of this relationship, and it can end unhappily because it is based on one gifting the fruits of power, and a corresponding sense of gratitude in the other.

The fundamental differences between the two models are summarised in Table 3. The developmental model reinforces mutual negotiation, power sharing and learning, with an end point (goal or time or both) built into the relationship and the means of achieving the learning is through stimulating insight. By contrast, the sponsorship model is a more parental relationship, with the mentor using her power for protecting, providing opportunities, giving advice and expecting reciprocal loyalty. These characteristics are juxtaposed in the table to illustrate their differences more clearly.

Table 3: Developmental versus sponsoring mentoring (Clutterbuck, 2009, p. 20)

Reproduced with the permission of the publisher, the Chartered Institute of Personnel and Development, London (www.cipd.co.uk).

Developmental mentoring	Sponsoring mentoring
Mentee (literally, one who is helped to think)	Protégé (literally, one who is protected)
Two-way learning	One-way learning
The power and authority of the mentor are "parked"	The mentor's power and influence are central to the relationship
Mentor helps mentee decide what he/she wants and plan how to achieve it	Mentor intervenes on the mentee's behalf
Begins with the ending in mind	Often ends in conflict, when mentee outgrows mentor and rejects advice
Built on learning opportunities and friendship	Built on reciprocal loyalty
Most common form of help is stimulating insight	Most common form of help are advice and introductions
Mentor may be peer or even junior – it is experience that counts	Mentor is older and more senior

Clutterbuck argues that the reason for confusion about what mentoring means is that the development of "mentoring concepts and behaviours has been strongly influenced by culture – both organisational and national" (Clutterbuck, 2009, p. 11). He argues that the differences between US models and those in other places, including New Zealand, are that mentoring "…begins from fundamentally different assumptions about the role and nature of mentoring" (p. 12). The model of mentoring which he has called developmental is more commonly found in the UK, Europe, Australia and New Zealand. The cultures in these countries, he says, support "a model that emphasizes mutuality of learning and the encouragement of the mentee to do things himself or herself" (pp. 12-13). The claim that in these cultures the assumptions at play are fundamentally different from those at play in the US is also reinforced by New Zealand

researchers (Chiles, 2006; Clark, 2004). Chiles, in her thesis on mentoring identity, claims that the New Zealand style is more suited to the developmental rather than the sponsorship model. The current study uses a developmental model and it is essential to explore this model fully.

A Closer Look at the Developmental Model of Mentoring

Clutterbuck throws light on other reasons that developmental mentoring is different from sponsorship mentoring. The time period is shorter, and generally the relationship is about half way through after six months; the mentor has no role in the day to day work of the mentee, other than as a sounding board; and, after the midpoint is reached, the mentor's challenges are deeply probing and analytical (Clutterbuck, 2004, p. 112). He also claims that after the midpoint (six months), the mentee relies less and less on the mentor's judgement or seeks her approval less often (2004, p. 112). This is an adult-to-adult relationship, where the needs of the mentee frame the purpose of the relationship through individual negotiation and the increasing accomplishment of the mentee. This description closely approximates the group model of mentoring analysed in this study.

Clutterbuck's (2009) developmental model reinforces the values of mutuality in the learning relationship, and the interactivity between the mentor and mentee, as the former encourages the mentee to act autonomously. Clutterbuck, however, makes it clear much depends on the couple: "every relationship operates within a context" (p. 14).

The first step is the expectations of mentors and mentees within their particular context. When personal development is the desired outcome, the most effective relationships are those in which the mentee is relatively proactive and

the mentor is relatively passive or reactive. The opposite is true for relationships that are based on a sponsorship model. Clutterbuck states that the success and longevity of the relationship relies on each finding some positive gain for their mutual efforts (Clutterbuck, 2009, p. 15). The model is shown diagrammatically in Figure 1.
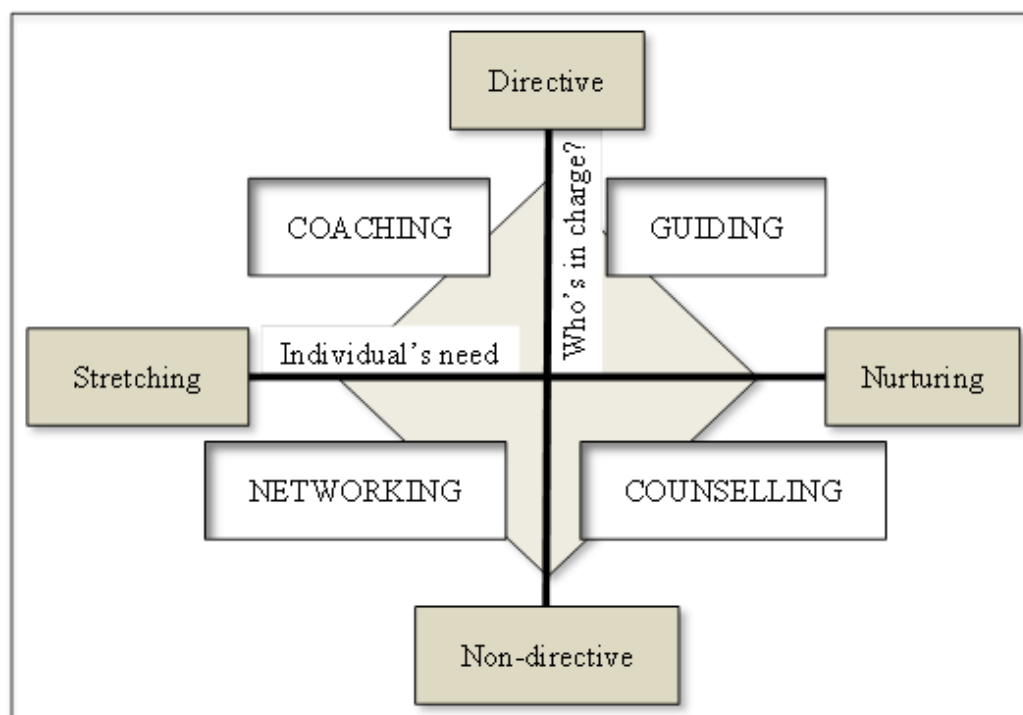
Figure 1: Developmental mentoring: four basic styles of helping matched to two dimensions of "helping to learn" (Clutterbuck, 2009, pp. 15 - 17)

Reproduced and adapted with the permission of the publisher, the Chartered Institute of Personnel and Development, London (www.cipd.co.uk).

The diagram shows a model of mentoring, with the vertical and horizontal lines representing two dimensions of the "helping to learn" relationship. The first dimension is "Who's in charge"? If the mentor is mainly responsible for managing the relationship, then it is towards the directive end of the dimension, whereas if the mentee is encouraged to be self-reliant, the relationship is towards the non-directive end. The second dimension concerns the

individual's need. This can be more towards being stretched and challenged to learn, or more towards being nurtured – supported and encouraged. Within these two dimensions the diagram positions "four basic styles of helping to learn behaviours": coaching, guiding, networking and counselling. These are placed depending upon their characteristics vis-à-vis the two dimensions. For example, coaching is relatively directive, but it is often challenging as well, while counselling tends more to be nurturing and non-directive. The diamond shape in the diagram represents how a developmental mentoring approach uses each of the four helping styles with the mentor "having sufficient sensitivity to the mentee's needs to respond with the appropriate behaviours" (p. 18).

Clutterbuck's model can be seen to relate well to the definition of mentoring used in this study, which is also derived from the definition from the NZCOM consensus statement on mentoring quoted earlier. The latter definition emphasises the negotiated nature of the mentor-midwife relationship; it lists challenging, supporting and guiding as functions of the mentor; and it talks of not always giving answers, but encouraging the mentee midwife to research, explore and reflect. These are all aspects which align well with Clutterbuck's developmental model. Clutterbuck's model is useful when considering how well the group mentoring model meets expectations of a developmental mentoring approach to mentoring new graduates.

New Graduates: a "Deficits Model"

This section examines what is known about the needs of new graduates and in particular new graduate midwives. It draws on a small body of New Zealand research on the experience of new graduates in midwifery (Kensington, 2005,

2006) and in nursing (Hall, 1998) as well as international research. In most of the world literature, new graduates in midwifery are subsumed under the umbrella of nursing so it seems reasonable to use nursing literature to inform new graduate theory in midwifery, although some research from other disciplines is also relevant (Rochester, Kilstoff, & Scott, 2005; G. Scott & Yates, 2002).

New Graduates Seen as Being Deficient and Facing Transition Stress

International research on new graduates, whether from the perspective of the clinicians, the profession or tertiary educators, assumes the standpoint of a need to redress what is perceived as the new graduates' skills deficit (Del Bueno, 2005; Sorensen & Yankech, 2008). I call this the "deficits model" of new graduates. The outstanding feature of most research is that the new graduates are seen broadly as clinically deficient, and specifically in need of technical skills or critical ways of thinking. At the point of entry, new graduates are perceived as inadequate, and as not fully integrated professionals. The reasons given are that these graduates lack knowledge about being in practice (commonly called a theory-practice gap) because they are transitioning into practice, and as they do so, they are suffering from transition or reality shock; as a result, their critical thinking skills are inadequate or absent. So serious is this deficit that some believe safe health care is compromised.

Internationally research on new graduates seems focused on their lack of skills, rather than on their particular concerns, or the environment or culture within which they find themselves. The research typically represents new graduates as entering practice with theoretical knowledge, but also represents this knowledge as of limited use, because it has not yet been given practical

application. Two authors have asserted that this gap, experienced by nurses transitioning from nursing school to nursing practice, makes the development of critical thinking more difficult (Sorensen & Yankech, 2008). Ever since this gap has been recognised, it has been examined and researched. Some writers argue that the gap creates a productive tension (Rafferty, Allcock, & Lathlean, 1996). Others argue that the lack of new graduate skills creates significant safety issues. There is a sense of urgency about addressing the perceived gaps by encouraging specific teaching programmes (Del Bueno, 2005). According to Sorenson and Yankech (2008), the gaps are bridged by educating preceptors in understanding "...how learning occurs, [and] the concepts involved in critical thinking to maximise the learning experience" (p. 214). For Falcione, Falcione and Sanchez (1994) nursing education is more than a "fact loading process", and is instead a mix of keen observation, clinical judgement and problem solving capacity. This lack of practice knowledge in new graduates is said to be complicated by workforce shortages resulting in a less experienced skill mix overall which increases the risks to patients. Therefore the new graduate has to contend with not only their own sense of vulnerability and a perception of them by the other registered staff as deficient, but also the variable capacity of preceptors to support them (Clarke & Aiken, 2003).

The novice is seen by Clarke and Aiken (2003) both as entering an environment of workforce shortages for which they inadequately prepared, and as having unrealistic expectations placed upon them. "When a nursing unit has too few experienced nurses relative to inexperienced nurses and when those experienced nurses are overburdened, it becomes less likely that complications will be detected in a timely manner" (2003, p. 44). Therefore the deficit is

actually within the environment within which they enter, and is not necessarily a reflection of their preparedness for the work (Rhéaume, Clément, & LeBel, 2011). Workforce shortages compound the problem, faced by new graduates, of being accepted and integrating gracefully.

The stress of transition affects new graduates in any profession on entering the workforce. After two weeks of preparatory support which had helped allay their anxiety, a group of new graduate doctors found "being on call remained "terrifying': the combination of responsibility and isolation still nerve-wracking" (Berridge, Sharpe, & Roberts, 2007, p. 125). This research report by Berridge et al. on new graduate doctors strongly suggested that new graduates' confidence and competence were directly related to the quality of the support they received. They argued for the use of bridging programmes and a "supported transition from observer learner to accountable clinician" (2007, p. 126). The clinical support recommended included shadowing and a two-week preparation. The report seemed to almost scorn the degree of anxiety felt by the transitioning doctors: "However the dominance of anxiety at the commencement of a career appears unbalanced" (p. 126). This comment is immediately followed by discussion about the deficiencies in the undergraduate programme and the problems of indemnity if students had more of a slow transition with increasing responsibility before qualifying. There is no doubt that this transition is a time of enormous vulnerability for the new graduate, and how to find the means to appropriately support particular practitioners to safely enter their respective professions is a vexed issue.

Research on New Graduate Midwives in New Zealand

The transition of new graduate midwives has been studied in New Zealand, and experiences here have been shown to be not unlike those experienced by new graduates elsewhere. According to Kensington (2005), new graduate midwives in New Zealand transition into practice "betwixt and between" student and midwife; although they are not quite one or the other, they "understand their new social state, their responsibilities and accountability as autonomous practitioners" (p. 161). There were nine new graduates in Kensington's study; though this is too small a population from which to generalise, the study was a rare look at the voluntary, non-government funded mentoring of self-employed new graduate midwives from the new graduate's perspective. Four themes emerged from the experiences of "crossing the threshold": preparedness for independent practice, the challenges of self-responsibility, feelings of being "on trial" and "being tested", and feelings of having done "their time" (p. 161).

The midwives interviewed by Kensington about their "preparedness for practice" were in general happy with their preregistration content knowledge, and did not know quite how they could have been prepared any further for self-employed practice. They commented that their transition to practice was made possible because as one said, "I had so much support"; another said "I felt I could do it because I knew I was well supported" (Kensington, 2005, pp. 162-163). Another said that her technical ability to manage emergencies had been tested and served her well: "I have had two emergencies and have felt pretty ok about how I chose to manage that and thankfully they both had a good outcome" (2005, p. 162).

Kensington (2005) identified a theme of "the challenges of self-responsibility", which was keenly felt by the midwives as they confronted the vulnerability of self-employed practice in their first year. Kensington broke this theme into three aspects: challenges of independent practice, understanding responsibility and accountability, and defining your own boundaries. One independent practitioner who felt vulnerable in her relationship with clients said "you realise how quickly people [clients] can turn on you and how quickly if things don't go exactly the way a client wants in a birth" (p. 169). Yet for another the challenge of self-responsibility was in how hard she found the work: "there were days when I just, it was too hard and I thought oh I should have just gone worked in a hospital somewhere" (p. 168). Another described setting time limits around her practice to ensure she had family time: "I would explain to my women when I took them on, when I booked them, that this was what I did and that was quite difficult to start making my own, deciding how my practice would be for myself" (p. 173). The New Zealand continuity of care model reinforces the responsibility of practitioners to practise within their own limits, says Kensington, unlike the United Kingdom where the midwives have no control over their case-load, and this is expressed as dissatisfaction with continuity of care by midwives (p. 173).

The third theme was new graduates feeling as if they were "on trial" and "being tested". This was characteristically experienced when they admitted their (often labouring) clients to a hospital. The demeaning tone and questioning by staff had the effect of undermining the new graduate's confidence; but further, "that patronising talking in front of the client that makes it really difficult to have a client being confident in you" (Kensington, 2005, p. 174). One of the mentors

in Kensington's study described her role as one of a buffer "between her [new graduate] and the facility in preventing that stress going on her" (p. 175). This sense felt by the new graduates of having one's practice scrutinised and of feeling others' doubts about their capability were expressed not only by hospital midwives, but also by other self-employed midwives: "I really worry about you being out there with so little experience in independent practice" (p. 175). The effect of others' doubts and concerns took a toll on the new graduates' confidence.

The fourth theme of "having done their time" captured the new graduates' feelings of finally being accepted as a midwife at the end of their first year. They experienced this sense of having "done their time" through extremes of responses from colleagues, from indifference to encouragement. One poignant story from one of the new graduates clearly illustrated the changes in attitudes to her over the year:

> …it was interesting because at the beginning of the year I would have had lots of possibly negative comments…all of a sudden I had all these women who had seen me from the beginning of the year to now and their level of support and nurturing was huge (Kensington, 2005, p. 177)

It seems that the model of new graduates as being deficient holds true amongst midwife practitioners also whether the new graduate is educated for autonomous practice or not, and therefore the developmental model of mentoring used in this study tests the idea of deficiency quite directly. If indeed the shock of the transition renders the new graduates deficient, then logically the ideal support for new graduates would need to be far more intrusive, in order to ensure the safety

both of clients (patients) and of the graduates themselves. The developmental model would be an unsuitable model of mentoring if the new graduate midwives were deficient or inadequate as practitioners.

Support for New Graduates through Transition

The concept of "transition to practice" has, like the "theory to practice gap" been the subject of much research.The experience of this transition, particularly in the first graduate year, has been recognised as stressful by many writers (Andrews & Wallis, 1999; Hobbs & Green, 2003; Newton & McKenna, 2007). Kramer (1974), a nurse academic from the US, was the first to name the experience of new graduates in their first months of work as "reality shock". The term captured the essence of how new graduates felt in their first few months at work. Another nurse academic, Duchscher (2009), recently researched Canadian nurses transitioning into an acute care setting. She expanded on Kramer's "reality shock" term, renaming it "transition shock", after analysing the stages as doing, being and knowing within a non-linear journey (2009, p. 1103). She found that new graduate nurses often identify their initial professional adjustment in terms of feelings of anxiety, insecurity, inadequacy and instability. Her research provides a theoretical framework for managers, educators and experienced practitioners. She claims that, although many studies have been made of the transition process, few since Kramer have "distilled out the nuances of the transition experience at various stages" (Duchscher, 2008, p. 443). Her framework acknowledges that this transition is not only a professional development journey, but also a personal one.

The implications of providing appropriate support for new graduates are far reaching. Junior doctors surveyed in one study showed their concerns were "...about not coping clinically" (Berridge, et al., 2007, p. 120). These fears were addressed by providing additional skills training and "shadowing"; However the factors which actually ameliorated their anxiety most effectively were getting to know colleagues and having collegial support (2007, p. 126). This indicates that programmes which are responsive to individual needs such as developmental mentoring, have a place. Unfortunately, however, it is more common for programmes to address only what is perceived as a new graduate skills deficit, such as a lack of clinical judgment, rather than combining this with a support structure such as developmental mentoring (Del Bueno, 2005; Sorensen & Yankech, 2008).

In contrast to this focus on new graduates' perceived lack of skills, a Canadian study considered environmental factors (Rhéaume, et al., 2011). The study surveyed new graduate nurses who had participated in mentoring programmes. The data were collected over five years, with a focus on retention, although other variables were also studied. Rhéaume used a correlational analysis to explore relationships between key variables: characteristics of the transition programs, empowerment (defined as sense of control, competence and goal internalization), work environment, and intent to leave. Interestingly, empowerment score and intent to leave were only moderately correlated: "higher empowerment levels were linked to lower intent to leave"; but a significant relationship was found between "overall work environment scores and intent to leave" (2011, p. 490). This study at least widens the focus out from the new graduate and to a more comprehensive view of the environment into which they

are to be socialised. By contrast the "deficits model" does little to promote the supportive learning environments needed for new graduates transitioning from the world of study to that of practice.

Backward Mapping of New Graduate Needs

Recently a new multidisciplinary project called "backward mapping", analysing the characteristics of successful graduates in their first few years, has provided another approach to understanding the early development needs of graduates. The results provide evidence "that while capability in technical skill is necessary for successful practice as a nurse, it is certainly not sufficient" (Rochester, et al., 2005, p. 118). The cross disciplinary study was undertaken in Accounting, Architecture, Engineering, Information Technology and Sports Management to backward map characteristics of successful graduates (2005). The cross disciplinary characteristics found included technical capabilities, however, emotional intelligence capabilities ranked even higher. The responses by engineering graduates showed that they were aware of the importance of technical capacity, but were also aware that other capacities as well were required for effectiveness in practice, such as "being able to negotiate your way through multiple perspectives" (G. Scott & Yates, 2002, p. 371). The respondents agreed that sharing real world practice problems with others would develop attributes for effective practice, such as "studying, analysing, experiencing and seeking to resolve" problems. The respondents also acknowledged that these real situations have "an emotional, intellectual as well as a technical dimension" (2002, p. 371).

In a study of nursing graduates who were successful in their first few years, the graduates ranked the following interpersonal emotional intelligence items as of the highest importance: "the ability to empathise and work productively with people from a wide range of backgrounds"; "a willingness to listen to different points of view before coming to a decision"; and "to be able to use networks of colleagues to help me solve key workplace problems" (Rochester, et al., 2005, p. 183). The aspects of personal emotional intelligence which ranked the highest for both the engineers and the nurses were "…being willing to face and learn from my errors and listen openly to feedback…being able to remain calm under pressure and when things go wrong…and wanting to produce as good a job as possible" (2005, pp. 183-184). This innovative interdisciplinary research helps support the type of new graduate support researched in the present study. However, because it is focused on successful individuals, rather than on ways of changing culture, it is unlikely to unseat the narrowly defined, traditional "skill focussed" approaches to the early post-graduate years.

Therefore an exploration of research on groups and group mentoring is of great importance here.

Group Mentoring

The shortage of one-to-one mentors due to workforce pressures led to the innovative group approach to mentoring researched in this study. This section examines the literature on group approaches to mentoring and similar developmental and support relationships.

There is no doubt that mentoring was traditionally conceived as a one-to-one model, involving a senior mentor and a less experienced protégé. Nearly all the research into mentoring in nursing takes it as read that the mentoring relationship will be one-to-one. Yoder considers that career development relationships are inevitably one-to-one, both in her concept analysis of mentoring (Yoder, 1995, p. 17) and in her research on nursing in the USA. The New Zealand research literature and the NZCOM consensus statement and MFYP programme all envision mentoring as a one-to-one relationship (Chiles, 2006, 2007; Clark, 2004; New Zealand College of Midwives, 2000, 2007). The models being used, however differ, with developmental rather than sponsorship mentoring being encouraged in the New Zealand context.

In recent years, a number of examples in the literature on mentoring and other developmental and support relationships have been based on groups. For example, a 2010 Google Scholar search for ALLINTITLE: (group mentoring) found 54 articles, 48 of which were in the area of "Social Sciences, Arts, and Humanities". Several of these are not relevant to the current study, because they describe a *mentor-led* group approach to support and developmental programmes for school-children and adolescents, particularly adolescents from disturbed and under-privileged backgrounds.

A similar search for ALLINTITLE: (group supervision) returned 443 articles, 428 of them in "Social Sciences, Arts, and Humanities". These articles nearly all discuss clinical supervision in group settings used in counselling, psychotherapy, mental health nursing and social work; these settings are sometimes used particularly to help participants learn about working in and using groups in their own work situations. Although not directly comparable to the

type of group mentoring approach in this study, group supervision research is described further below because some of the research groups and how they function is relevant.

The original notion of group work began in 1946 in Connecticut where Lewin (Director at Research Centre for Group Dynamics at Massachusetts Institute of Technology) was asked to train the first "T group" (T stands for training in human relations) leaders (Yalom, 1975, p. 459). The T group was the ancestor of the encounter group movement. This movement, which peaked in 1975 after 15 years of rapid growth, began the human relations education movement. Rogers (1968) predicted that such experiential learning would bring such changes to education that schools would become less important, and instead "thoughtfully devised environments of learning" would evolve in their place. In these "environments of learning", the professor would be replaced by a "facilitator of learning, chosen for his facilitative attitudes as much as his knowledge" (1968, p. 274). Rogers believed that by the year 2000, industry would be paying "as much attention to the quality of interpersonal relationships and the quality of communication as they currently do to the technological aspects of their business" (p. 276). Although we might not yet be where Rogers predicted, certainly learning in groups has increased; some are specifically developed to encourage learning about something specific, and others are directed toward interpersonal development. Some supervision groups are structured for specific professional learning and these also entail conscious interpersonal development.

Proctor (2006), a prominent counsellor in group work and learning, describes four types of supervision groups. Three are led: the authoritative group,

participatory group, and co-operative group supervision with the lead supervisor. The fourth is a peer supervision group where "members take shared responsibility for supervising or being supervised" (2006, p. 38). This fourth group provides a reflective space for each participant, and is described as a "supervisor-full group, since each member has agreed to be one of the people to whom the others are accountable for competent, confident, creative and ethical practice" (p. 56). For Proctor's counselling students, clinical supervision in a group grew out of individual one-to-one encounters which had become uneconomical. Individual one-to-one encounters were previously required to occur for the full two years of the program. The new design was for a group approach for the first year, and individual one-to-one supervision in the second year. She argued that "if supervisees learned to use the group well, experience in that challenging environment would help them use their individual supervision economically, creatively and effectively"(p. 1). All of these clinical supervision groups were either led by a supervisor or in the fourth example, peer supervised. These are different models to the conception of the group mentoring model in this study of new graduates and mentors.

The next three sections describe the few research studies found which are more directly relevant to the present study. The first section describes a study of group supervision of UK midwives; the second is about group mentoring of new graduate nurses in the US; and the third looks at a few studies of group approaches to mentoring in other disciplines.

A Study of Group Supervision in UK Community Midwifery

Ruth Deery (2005), a UK midwife, looked at the support needs of a team of eight community midwives over a period of six months to determine the value of group clinical supervision. Her action research study represented "the first action-research study of its kind in midwifery to move beyond acknowledging the existence of stress and burnout by devising and mobilising a support mechanism for midwives" (2005, p. 163). Deery hoped that by providing education for midwives about the concept of clinical supervision and having the midwives experiencing regular group clinical supervision sessions, they might develop their own model of support (p. 164). Deery did not participate in the clinical supervision group, but interviewed the midwives who were taking part in the clinical supervision process three times over the six months.

The midwives had contracted with the clinical supervisor to attend the clinical supervision sessions and to maintain confidentiality, but despite the contract, attendances were poor. The scarcity of midwives in the workforce created pressure on the participants, and as they did not have adequate midwife back up, they were too busy to attend the supervision sessions. Though Deery had worked with management to ensure time was made available for the midwives to attend clinical supervision, in the event they were unsupported, and management showed little understanding of the enormous pressures on midwives.

In the interviews, Deery found that the midwives were unaware of their emotional needs and resisted the opportunity for reflection, preferring instead what she called "pseudo-cohesion", in order she says, "to mask unsupportive

behaviour within the work team" (2005, p. 171). She also found that the midwives felt unprepared to deal with collaborative working, and she interpreted this as an educational gap in midwifery. Midwives, she said, needed to be educated both to become more psychologically aware, and to have an understanding of group-work theory. She was surprised by the extent to which her data analysis showed stress in the midwives – even though she was aware of the research about stress and burnout being endemic in the profession and also the serious lack of support (Ball, Curtis, & Kirkham, 2002; Kirkham & Morgan, 2006 (a); Kirkham, Morgan, & Davies, 2006; Kirkham & Stapleton, 2000; McIver, 2002; B. McKenna, et al., 2003; L. McKenna, 2003; McLardy, 2003). She says her second reading of the interview data was cathartic, as "the full extent of the midwives" stress and lack of support was realised" (Deery, 2005, p. 170).

Despite the clinical supervision not being well attended, the lack of management support, the recruitment and retention problems, and the midwives' lack of insight, Deery clearly sees clinical supervision as a means to achieving much needed support for over-stressed midwives. She argues that in order to "develop good relationships with different women midwives clearly need to experience relationships which nurture their own growth" (Deery & Kirkham, 2006, p. 126). The community team which Deery studied had little or no autonomy over their work, and they were unable to reduce or reschedule women in their case-load in order to attend the group meetings (Deery, 2005). Although democratic principles lie at the heart of action research, the midwives were not in a position to collaborate or participate freely, because they had limited autonomy and few choices over their case-load.

Deery acknowledges the numerous difficulties she met "on the ground" in her study (2005). She claims that in the UK, the midwives lack education in psychotherapeutic concepts, and group-work theory has had a detrimental effect on midwives, who lack an awareness of their interactions with others. She notes that without such education, midwives will not be skilled in collaborative ways of working, which is an important principle for quality in practice both within and between disciplines. Deery contributes to the international debate about how best to support professional development in midwifery, and illuminates the need for an understanding of the commitment that group members must make before a group can be successful. This understanding made a contribution to the design of the present group mentoring model.

A Study of Group Mentoring In New Graduate Nurses

While Deery planned a group approach to supervision in an established community midwife team, Scott and Smith's (2008) research was an example of group mentoring in nursing which emerged as a pragmatic response to practice need. In a 261-bed North Carolina hospital, there had been practical difficulties in the one-to-one mentoring that had been provided for new graduate nurses, so it was disbanded. The practical difficulties were felt by both the mentors and protégés; they included the extensive time commitment, finding mutually suitable locations, and finding mutually suitable times to meet.

A commitment from three nurse educator specialists then enabled a preceptorship programme, along with group mentoring, to be put in place for 25 new nurses. A table distinguishing the role of the preceptor from that of the mentor showed that both preceptor and mentor socialised and supported the

transition of the new nurse. The mentor was described as the nurturer, role modelling the behaviour and values of the institution and advocating when necessary; and the preceptor validated clinical skills, identified areas for skill development, and role modelled safe practice within the unit where the nurse worked (2008, p. 234). The 25 new graduate nurses had four day-long group meetings with the three nurse educator specialists over the course of their new graduate year. In addition, the three nurse educators made themselves available in person and by pager for the 25 nurses should they want to contact a mentor whilst on duty. An evaluation of the programme was made using a focus group session and an open-ended survey. Scott, a faculty member of the East Carolina School of Nursing who had not been involved in the mentoring group, ran the focus group and analysed the survey, to which 13 nurses responded (E. S. Scott & Smith, 2008). The mentoring group element was overwhelmingly considered positive. The group meetings were particularly valued, with 12 of the nurses (92.3 %) rating themselves as very satisfied with the process and the remaining participant as satisfied (2008, p. 237).

A feature of the article relevant to the current study is the mention of the effect of peer support. "Although the project's intent was to provide senior guidance from nurse educational specialists to new novice nurses, it changed into a program that also allowed new graduate nurses to mentor each other" (2008, p. 238). What this article has described is a peer group of 25 new nurses who had a range of professional support available, including individual preceptors and three senior staff available to them should they wish to contact them whilst on duty. There is no breakdown provided on the frequency of contact between new graduates and the nominated "mentors", apart from the four meetings over the

year, but the comments from the survey of the new nurses showed a sense of appreciation that the senior staff cared about them. Other researchers have commented on the value and importance of not only traditional hierarchical forms of mentoring, but also of peer networks as alternative forms of effective support (Dreher & Ash, 1990; Eby, 1997). The importance placed on the peer group is a significant and important feature of the design of the group mentoring analysed in this study; it included the close working relationships of the four new graduates. The midwifery and nursing studies described above were the only relevant research found from these disciplines, so the next section looks at relevant studies from other disciplines.

Group Mentoring in Other Disciplines

This section describes a number of studies found from database searches looking for research into group mentoring in disciplines other than nursing and midwifery. In 2008, two databases (Cinahl and Proquest) were searched for "group mentoring" but only one study was found Singleton's (1993) in Proquest.

Singleton's research about group mentoring was set in a theological college in the USA (1993). It is interesting because it demonstrates the different ways in which the term "mentoring" is used, and the clear difference between a sponsorship approach and a developmental approach to mentoring. A Mentorship and Professional Socialization questionnaire was sent to 244 theological students, using a stratified random sampling method. The students were enrolled in the Master of Theology program at the Dallas Theological Seminary. Questionnaires were sent to determine the seminarians' vocational commitment and spiritual formation experience after their group work (Singleton, 1993, p. 72). The

Master's students in the sample were enrolled in groups spread over the eight modular courses that provided professional socialization into the work of the ministry. In the practice world there was a perceived lack of attention to professional values; the "mentoring" groups were in part addressing this practice gap by providing professional role models to lead the groups. The term for the process in this study was "discipleship", which was used interchangeably with the term "mentorship" (1993, p. 56). The discipleship (mentoring) groups were defined in the questionnaire as a "small group (2-10) that meets weekly in order to discuss biblical principles and the specific applications of those principles to problems faced or procedures followed in Christian ministry" (p. 156).

The courses were aimed at clarifying the ministerial role. Although initially the student needed to attend only the groups, they later learned to lead a group, and finally led a group themselves over the eight courses. Learning by practising leading was seen as one means of embedding an appropriate professional role identity for work in the ministry. Singleton argues that role confusion and role ambiguity have been shown to be positively related to job dissatisfaction, tension, anxiety, and the propensity to leave (p. 68). Singleton's model of mentoring appears to fall clearly into the sponsorship model, with statements such as: "mentoring emphasizes the sponsor or master perspective" (p. 52). The system of professional socialisation is structured explicitly to meet the needs of the ministry as a profession. The training institution assesses the course outcomes from the student's compulsory assignment work. The focus of this mentoring was on modelling professional expectations and assessing the students' learning which is at odds with a developmental approach.

A definition of mentoring which includes notions of voluntariness and choice is not fulfilled in this case (see Table 1). In the present study as in Table 1, mentoring is characterised as: "a voluntary relationship between registered professionals where the inexperienced or novice practitioner chooses the experienced practitioner as an appropriate guide through a process of attaining confidence" (Lennox, et al., 2008, p. 18). Singleton likens the Theology Master's programme to the clinical years of medical training where trainee doctors spend time in small groups, and whilst focused on content, they also receive role modelling and professional socialisation from the example of their medical consultant lecturers. "The use of mentorship in the preparation of professionals is preferable for the purpose of providing students close contact with appropriate role models" (Singleton, 1993, p. 63).

The relationships described by Singleton would be more appropriately characterised as a preceptorship process than a mentoring one, on at least two counts. The first relates to Table 1 (p. 38), which distinguishes the mentor role from the preceptor one as: "The preceptor role is described differently to mentoring focusing on the content to be covered rather than on the new graduate's experience of practice". Secondly, Singleton's group leaders were allocated rather than chosen by the participants, and in Table 1 preceptorship is distinguished from mentorship: "particularly in regard to the preceptor being allocated to, rather than chosen by, the new graduate".

The main difference between preceptorship in hospitals and the discipleship of Singleton's study is in the purposes they serve. Singleton's students were being taught a set curriculum to meet the perceived needs of the profession, just as new hospital employees are trained to meet the needs of the

institution. In neither case are the needs of the individual as an active participant considered. This distinguishes emancipatory mentoring from other forms of professional support. Singleton's mentoring represents, as he says, discipleship, so that the learner is being supported to learn a particular way of being and knowing. Clearly Singleton's model if it is to be considered mentoring at all, most closely approximates the sponsorship model. By contrast, the developmental model is characterised by a focus on the mentee's needs, as perceived by them and by the mentor.

The next example of research into group mentoring comes from a US faculty of education and represents the only research found where group sessions were recorded and analysed as was the plan for the present study of group mentoring (Smith, et al., 2003). This example of educational research into group mentoring involved three doctoral students who taught classes over a year and who met weekly with their lecturer, Steve. The process was collegial, and in "…serving as a mentor, Steve did not enact a traditional and hierarchical role as expert" (Smith, et al., 2003, p. 14). The mentoring sessions were probing and engaged all four in reflective and reasoned thought about their teaching practices. The study entailed journal-keeping, class meetings were videotaped, the lecturer wrote memos of what he had learned, and over the year, "the four of us met regularly to share insights and to synthesize learnings and perspectives, all of which culminated in this paper" (Smith, et al., 2003). This study presents particular case studies to demonstrate how the mentoring sessions supported learning. The mentoring sessions "created opportunities for us to interrogate the depth of our English teaching content and methodology"; "provided occasions for us to talk and learn about our practice in coherent, meaningful ways with the

support of our peers and our mentor"; "offered multiple perspectives which relied on our teaching and the design of the English methods course; and challenged us to examine our assumptions about teaching preparation students as learners" (Smith, et al., 2003, p. 14). As a result of this mentoring initiative, more formal mentoring of beginning doctoral students has been put in place as a College Teaching Practicum (Smith, et al., 2003, p. 24). This study seems to be clearly an example of the developmental model of mentoring, where the lecturer was acting as facilitator and not as expert. The importance placed on "who's in charge" and on meeting individual need seems to have been acknowledged in this case of post-graduate mentoring (Clutterbuck, 2009, p. 15).

The remainder of this chapter describes a number of studies that were part of the 48 papers obtained from the Google Scholar literature search for group mentoring. On examination, eight studies appeared relevant to the present study. They concerned new graduates and mentoring in groups or circles; of these, three were research articles (Darwin & Palmer, 2010; Johnson, 2007; Ritchie, 1999; Ritchie & Genoni, 2002; E. S. Scott & Smith, 2008; Shaw et al., 2003), two were programme evaluations, two were informed opinion pieces (Edwards & MacDonald, 2009; Raumati Hook, Waaka, & Raumati, 2007) and one described a group mentoring method (Whitbeck, 2001).

Ritchie claims that her evaluation of a programme for graduate librarians transitioning into their first professional positions is the first quasi-experimental research design of a group mentoring programme (Ritchie, 1999; Ritchie & Genoni, 2002). The learnings from this evaluation were: that having "a calling" was significantly enhanced by the group mentoring programme; that one year of group mentoring is not effective as a single strategy for the development of

professional identity; and that group mentoring was effective for career development, but less effective in the psychosocial sphere. The authors propose introducing a third mentoring function, "professionalism", to the two initially proposed by Kram, career and psychosocial functions, which have been previously accepted (Kram, 1985; Kram & Isabella, 1985; Ritchie & Genoni, 2002). The notion of this third function was an interesting finding for those developing group mentoring for a profession. They also suggest that it may be appropriate to steer protégés away from exclusivity in their mentoring relationship, and instead use mentoring "…as a source from which to explore the various forms of support available in the wider professional group" (Ritchie & Genoni, 2002, p. 77). This idea of developing professional networks had also been suggested previously by Higgins and Kram (Higgins & Kram, 2001).

Another recent study (Darwin & Palmer, 2010) examined the experience of three mentoring circles in higher education, using surveys before and after each session, focus groups at the end of the programme, and interviews with the organisers. Three groups met for two hours every three weeks; one circle was in law/commerce and the other two in the health sciences. The circles were comprised of junior and senior staff. They tended to be unfacilitated meetings and discussed topics brought by participants. The groups found that building new relationships was the most valued outcome. These groups worked well for some, but others felt uncomfortable; however, this was not explored in-depth. The lack of facilitation points to a flaw in the structure of a group whose participants do not have a shared purpose, and indicates shared purpose would be important to the design of the present group mentoring study (Harvey et al., 2002).

Johnson's (2007) study on retaining and advancing librarians of colour evaluated a week-long mentoring/group programme which had been running for four years. The evaluation comprised a written questionnaire at the end of the programme and again 12 months later, plus an email survey of past participants over the four years. Each week-long "institute" involved 24 selected librarians, of no more than three years' experience, from under-represented US ethnic groups. The institute's programme was based around two group seminars each day, facilitated by two trainers and involving a graduate of the previous year. Each participant identified a mentor in their own home institution to provide support before and after the block course mentoring. All participants valued the networking with their peers, the creation of a community, and the facilitators' leadership; the programme was said to have influenced the individuals' careers and to have built confidence. There was evidence of retention and promotion of participants, as well as of collaboration between previous participants. The author also noted the importance of peer group support. This study suggests that facilitation, networking and the creation of a community are all important to the success of a group process and ought to be included in the design of a group model.

The Oregon Center for Complementary and Alternative Medicine undertook an evaluation of the success of supporting complementary and alternative (CAM) trainee researchers (Shaw, et al., 2003). The group of six trainees and centre directors met on a weekly basis, and the trainees presented their progress to the group. The programme had been going for two and a half years. The effectiveness of this programme was evidenced by 18 grant submissions, four poster presentations and seven submitted articles. Another

article describing a three month internship for nurse researchers which involved group mentoring; it asserted that the mentoring was valued by both junior and senior staff but no formal data was gathered (Edwards & MacDonald, 2009). The group did, however, have a clear purpose to which all participants subscribed.

Other articles on mentoring located during the literature search provided some interesting insights, including that mentoring within a Pākehā (European) framework was inappropriate for Māori (Raumati Hook, et al., 2007). The concept of individuality is quite different within Māori culture, and therefore mentoring "within a Māori framework" requires reworking mentoring concepts. Raumati Hook suggests that group mentoring may be more desirable than one-to-one (2007, p. 5).

An interesting related article was from an Australian academic, who reported how she had heard from a Māori colleague that one-to-one mentoring was unsafe, and as a result proposed a mentoring group for indigenous colleagues at her university. The resulting reflection on group mentoring was that it supports professional development and "should be an option available to Indigenous staff" (Asmar, 2007, p. 25).

The eighth article was a discussion document about introducing ethical norms into academic departments. This research proposed that group mentoring could find solutions to common problems and improve supervisee-supervisor relationships (Whitbeck, 2001). The group meetings took various forms and were held irregularly. In these meetings, faculty members led small group discussions involving eight to 12 graduate students, using written scenarios. The feedback suggested that the group method helped to establish norms and find constructive

solutions to common problems, improved supervisee-supervisor communication, and helped prepare supervisors. Again this group, although it did not meet regularly, was seen as largely successful because of a shared commitment to a purpose.

Summary

Research on mentoring has taken place over the last sixty years, and is fragmented. There does not appear to be much empirical evidence about group mentoring, and certainly I have found none where equal numbers of new graduates and mentors met regularly. Most group mentoring covered by research entails a small or not so small number of mentees and only one mentor. The new graduate research is focused predominantly on what new graduates lack in terms of experience; recent research has continued with this deficits thinking by looking at the attributes of those graduates who succeed, in order to use these qualities to augment undergraduate programmes. Mentoring has had a long history as a career development relationship, traditionally a one-to-one dynamic between an experienced person and one less experienced. In contrast to this one-to-one model, the value of group mentoring appears to lie in developing networks by increasing the numbers of relationships of trust, which enable greater sharing and reflecting on experiences. The literature suggests that peer relationships are promoted in groups and that these facilitate the development of confidence. A shared purpose is important to group formation and success. The needs of the mentee need to be the focus if the mentoring is framed as developmental; in that case, the responses of the mentor(s) should be highly flexible in accordance with that need.

In Chapter Three, the design and the theoretical thinking behind the study of group mentoring is outlined. The thinking develops from the researcher/participant's assumptions through to a description of the mix of methods and analyses which contribute to a constructive epistemology linking practice and theory. The methods for collecting and analysing the data about the group mentoring are outlined as are the ethical concerns associated with the study. These are followed by the approaches taken to ensure rigour and trustworthiness. The chapter ends with a reflexive account of the experience of being both a participant and researcher.

III.   DESIGN: PRAGMATIC MIXED METHODS – RICH DATA

SOURCES

Introduction

As outlined in Chapter One, the primary aim of this study is to describe a new group mentoring model in detail and to explore whether group mentoring supports new midwives to gain confidence. A second aim is to explore how the group mentoring model enables experienced midwives to support and pass on practice knowledge and wisdom to new graduates.

In this chapter, I describe the study designed to meet these aims. I detail its underpinning epistemological and methodological framework and the methods of data collection, as well as examine several ethical concerns and the rigour and trustworthiness of the research and analysis processes. Finally I give a reflexive account of my role as researcher-participant within this naturalistic study of a project in which I was both participant and researcher. The knowledge emerging from this study makes links between theory and practice.

The epistemology is constructivist: what Guba and Lincoln (1981) have previously called "naturalistic inquiry". In line with the assertion by Guba and Lincoln that "…both qualitative and quantitative methods may be used appropriately with any research paradigm" (p. 105), the methods of data collection include qualitative recordings of regular, formal meetings held between the new graduates and their mentors, and in depth interviews with all eight participants, as well as a range of quantitative methods: logs of telephone, text, or face-to-face contacts between the new graduates and their mentors and

visual analogue scales of confidence completed by the new graduates during their interviews.

Section One begins the chapter with a discussion of the epistemology and methodology that guided the research design. Section Two details the qualitative and quantitative data collection methods and their analysis as well as the ethical concerns that needed to be addressed. Section Three closes the chapter with a discussion of the rigour and trustworthiness of the study and a reflexive account of my participation and intention.

Section One: Epistemological Perspective

The knowledge claims that I make in this thesis are grounded theoretically within a pragmatic paradigm. Instead of arguing for the incommensurability thesis of either the quantitative or qualitative research paradigms, I follow a third theoretical option, as suggested by Morgan (2007, p. 447). His pragmatic approach is similar to Patton's "paradigm of choices", where the researcher decides what methods are most appropriate within a particular context (Patton, 1990, p. 68). This approach "accommodates" the values and limitations of both qualitative and quantitative paradigms, and provides an innovative theoretical space for practice research. The knowledge claims of this research are based on communicating across boundaries, in order that "knowledge which is either specific or context-dependent or universal or generalized" is accepted (Morgan, 2007, p. 72). A pragmatic approach avoids forcing a dichotomy between subjectivity and objectivity, because neither of these positions is ever absolute (2007, p. 71).

Pragmatism is defined as an approach "that debunks concepts such as "truth" and "reality" and focuses instead on "what works" as the truth regarding the research question under investigation" (Tashakkori, 2003a, p. 713). A pragmatic approach enables ethical and moral concerns (axiology) to have a place in the research, fulfilling the aims of the early pragmatists for whom "…gain[ing] knowledge in the pursuit of desired ends" was central, rather than an "…abstract pursuit of knowledge through inquiry" (Morgan, 2007, p. 70). Therefore the knowledge claims in this thesis are connected with the methods of research and the "world view" of a particular research community. The case for a research community holding "…a particular set of shared values" was made by Kuhn, who also acknowledged that there are no "…neutral algorithms for theory choice" (Kuhn, 1970, p. 200). He claimed that ultimately it is the "manner in which a particular set of shared values interacts with the particular experiences shared by a community" (1970, p. 200) that determines which set of arguments have sway.

Pragmatism "advocates for the use of mixed methods in research, and acknowledges that the values of the researcher play a larger role in the interpretation of results" (Tashakkori, 2003b, p. 713). Acknowledging those values is therefore important to the research. Individuals all see the world from a particular position; hence the researcher inevitably transforms what is seen when describing experiences or events. For pragmatists, "issues of intersubjectivity are a key element of social life" (Morgan, 2007, p. 72); it is this interactive element which is significant to all aspects of this research, both practically and theoretically.

Pragmatism best describes an approach where the use of inductive (data driven) and deductive (theory driven) inferences are connected and transformed by abduction. Abduction describes the process of moving backwards and forwards between induction and deduction, and finding points of contact for communicating between the research and the community of those readers and researchers who share similar world views. This enables the practitioner-researchers with similar values and concerns to be in a position to both critique and extend the research and/or practice innovations (Morgan, 2007). This accommodation aims to create new connections between research and researchers and between this thesis and other research.

The ability of the researcher to represent the process of the research and its assumptions, and then communicate those findings, is thus central to a pragmatic approach. However, getting facts right is not necessarily easy or trivial, nor are the meanings of participants' words necessarily clear or factually correct. This means that "conveying them in a coherent and useful manner" does provide a challenge (Sandelowski, 2000, p. 336). This study takes a factist approach to the rendering of the data, which means there is an assumption that the data is truthful and more or less accurate, and that the documentation represents what was said or really happened (Harris, 2003; Sandelowski, 2010). The thesis is therefore constructed from experiences both within this study and knowledge produced by others, which Colliver (2002) describes as, "merely the humble admission that human knowledge consists simply of our claims, our constructions" (p. 49).

This constructivist view sits very comfortably within this research, occurring as it did within the constantly changing world of practice. Writing

about nurses' fundamental patterns of knowing, Chinn and Kramer (2008) say "knowledge is taken to be a construction that varies across time, place, and person. Knowledge is constructed not only by us, but also for us, through social practices and systems of language and discourse" (p. 17). Social practices and interactions which construct knowledge may be verbal, written or may even include activities like dancing (2010).

The knowledge gained in this research, if carefully rendered, can be the catalyst for new insights to arise from our shared understandings. Despite the research being understood as appropriate and in relationship to a particular place and events, these insights can be used to enhance other social practices and discourses. The challenge for the researcher is to communicate the context and events well enough to provoke those insights.

The interplay between the processes of enquiry, the action and the description are influenced by the context and practice needs, which entail "inventing" structures and processes. In this study, the project (mentoring new graduates using a group mentoring process) occurred simultaneously with the need to capture research data to describe it; therefore those research structures were put in place alongside the project. A number of conscious assumptions were developed to give shape to what data could be collected and some initial thoughts about how the data might be analysed. These assumptions included:

- new graduates will gain practice knowledge from storytelling and/or conversations with mentors;

- new graduates will develop conscious strategies for collaborative professional relationships in the group;

- learning through reflective conversation and storying is appropriate for midwifery practice;

- group mentoring encourages flexibility in the new midwives because they are exposed to the different approaches taken by the mentors;

- new graduates will know when they need to ask for help and advice from mentors;

- the lack of attention to the social aspects of midwifery practice may be one of the underlying reasons midwives are leaving the profession;

- the new graduates will develop a clearer idea about the use of evidence to support their practice;

- the new graduates will develop an ability to critically appraise the evidence and have an understanding of the complex nature of using evidence in practice;

- new graduates will feel confident enough where appropriate to resist medicalisation of the normal process of childbirth; and

- new graduates may show increasing confidence in practice over the mentoring year.

The importance of establishing these assumptions is that they provided an initial data collection planning exercise, as we will see later. They were not developed to direct the project toward any particular aspect of interest. Because this was a naturalistic study, it needed to be open to whatever emerged, with minimal intrusion by the researcher. These assumptions directed the methodological options, and also helped to determine what methods would not be suitable to the

research priorities and assumptions. Below I very briefly review a few options to describe, by exclusion, why I chose the direction I have taken.

One option might have been to use action research, but this would have required that the mentoring meetings be problem-focused. The problem-focus is one of seven criteria for distinguishing action methodologies from other methodologies (Hart & Bond, 1999, p. 37). The implications of being problem-focused would have required manipulating the project in a particular direction, and this ran counter to the exploratory nature of the study. The cyclic nature of action research, with the interlinking of research, action and evaluation throughout the project, would have imposed a very different framework on the process. Predetermining the study's focus would have been inappropriate to the values, beliefs and purpose of mentoring the new graduates. It was important to this project that the relationship between the mentors and the new graduates was negotiated and that we were mutually responsive to one another throughout. However, neither the project nor the research methodology fulfils the criteria for action research. To name it as such would be over-claiming and would necessitate committing what Sandelowski calls "methodological acrobatics" (Sandelowski, 2000, p. 334).

The fact that I (the researcher) was also a participant might have made ethnography a suitable methodology, had the scope of the research been more focused on culture and less on the landscape of mentoring. Ethnography, derived from anthropology, is the study of culture; the primary method of data collection is participant observation. Whilst I did plan participant observation, it was only a small part of the data collection process in this study. It comes into play when I capture what takes place at the meetings, or during the provision of support for

new graduates whilst they attend clients in labour, activities in which I am implicitly involved as a participant. This "insider" perspective on the culture observed could provide fresh nuanced insights into mentoring and midwifery, but this is but a small part of the research. An ethnographic study certainly could use the types of data I collected, such as participant observation, interviews, visual analogue scales and call logs, but other helpful methods I used were not wholly ethnographic. Ethnography therefore represents only part of the broad and integrated data collection methods used in this study.

A mixed methods methodology seemed the most compelling of all the possible methodologies from which to choose. Certainly, where the study is qualitatively driven, the main reasons for a mixed methods design are for exploratory purposes (Cresswell, Shope, Plano, & Green, 2006). Mixed methods are more commonly quantitatively driven, with qualitative dimensions being supplementary. This enables the strengthening of causal links between the findings (Howe, 2004). However, in this study, mixed methods were chosen because of their ability to accrue more information. A distinction was made in this thesis between the method and the methodology, which is not always the case in mixed methods research. Sandelowski (2003) claims that there is no consensus on what mixing is involved in a mixed methods methodology, why a researcher mixes methods, what qualitative and quantitative entities are mixed, or what is it that distinguishes quantitative from qualitative research (2003, p. 322). The qualitative or quantitative assumptions are derived from separate epistemological and ontological traditions, which make justifying the integrated nature of the methods of data collection at the level of methodology inconsistent. In this case, the use of a third or pragmatic paradigm justifies the integration and

mixing of methods at an empirical level to make the thesis theoretically richer (Morgan, 2007).

Section Two: Methods and Analysis

As Table 4 demonstrates, logical (and multiple) forms of data and data analysis emerged from the assumptions stated above. The range of data collection methods included: taping and transcribing 31 group mentoring meetings; taping and transcribing 24 semi-structured interviews, which included the new graduates' marking a confidence scale; and collating 85 contacts made to and logged by the on-call mentor. The recordings of group meetings capture a range of information, such as storytelling, which is likely to provide insights into the practice knowledge needs or concerns of new graduates. Interviews provide the opportunity for individual accounts of practitioners' experiences, which may not otherwise be available to the research. Thematic analysis provides the compatible analytical tool for the meeting data. Later, when the interview data became supplementary to a focus on the meeting data, a combination of researcher questions and thematic coding of the interviews offers another lens on the new graduates' and to a lesser extent the mentors' experience. On the other hand, the on-call data captured the new graduates' need for midwife to midwife consultations and face-to-face clinical contact, so the analytic approach used was statistical. Table 4 illustrates how the assumptions underpin both the data sources and the analytic approaches taken, and supplies a justification for using multiple methods.

Table 4: Conscious assumptions, methods of data collection and analysis

Conscious assumptions	Type of Evidence/Data Collection	Data Analysis
New graduates will gain practice knowledge from storytelling and/or conversations with mentors. New graduates will develop conscious strategies for collaborative professional relationships in the group. Learning through reflective conversation and storying is appropriate for midwifery practice. Group mentoring encourages flexibility in the new midwives because they are exposed to the different approaches taken by the mentors.	Audio-taped group meetings. Semi-structured individual interviews with mentees.	Thematic analysis. Thematic analysis.
New graduates will know when they need to ask for help and advice from mentors.	On-call logbook for frequency and nature of contacts.	Simple descriptive analysis.
The lack of attention to the social aspects of midwifery practice may be one of the underlying reasons midwives are leaving the profession.	Discussions in meetings. Interviews.	Thematic analysis. Thematic analysis.

Conscious assumptions	Type of Evidence/Data Collection	Data Analysis
The new graduates will develop a clearer idea about the use of evidence to support their practice.	New graduates' reflections.	Thematic analysis.
The new graduates will develop an ability to critically appraise the evidence and have an understanding of the complex nature of using evidence in practice.	Audio-taped weekly group meetings.	Analysis of transcripts from audiotape.
New graduates will feel confident enough where appropriate to resist medicalisation of the normal process of childbirth.	Discussions in meetings.	Thematic analysis of meeting transcripts.
New graduates may show increasing confidence in practice over the mentoring year.	New graduates' reflections. Visual analogue scale of confidence. Meeting transcripts. Call-out logs.	Thematic analysis of interviews. Scores graphed individually and as a group Thematic analysis of meeting transcripts. Simple descriptive analysis of the number of mentor calls logged.

The data collection strategy focussed on recordings, gathering and assessing all forms of contact between the new graduates and the mentors. Group meetings and individual interviews were held and were recorded with all participants at the outset, at the half-way point and at the conclusion of the study. Call logs kept by the mentors recorded all telephone contacts and face-to-face clinical support.

Group Meetings

The meetings were recorded on an Olympus digital voice recorder, resulting in 65 hours of recording. Each week, after taping, the recording was transferred and stored in a folder on the researcher's home computer. Transcription was undertaken by a private provider who signed a Transcriber Confidentiality Agreement (see Appendix C). I describe the thematic analysis of these transcripts in Section Three of this chapter.

Interviews

Participants were interviewed to capture individual views of group mentoring three times over the duration of the study. The interviews were semi-structured to allow participants to discuss their experience of the mentoring, either as a mentor or as a new graduate midwife. The interview questions (Appendix D) were used as points of direction, but not as fixed and immutable reference points, so flexibility enabled the questions to be asked when the time appeared right within the context of the dialogue. This approach is based on feminist understandings of enabling the voice of the interviewee, rather than that of the interviewer, to dominate (Rubin & Rubin,

1995, p. 38). I was also aware of the risk that, as I was a participant-researcher, there was a possibility the new graduates might not disclose their negative experiences to me. Occasionally, individuals would disclose unique and unexpected experiences. Where appropriate, these findings of unique or unexpected experiences were able to be tested against other participants' experiences over the same or following interview cycle. These experiences were an important part of the design as well as the findings, as they stimulated conversations and changes to the mentoring project by the participants. The data collected was conversational, and often strayed from the mentoring project to clinical experiences which, though not directly related to discovering the value of mentoring, meant the researcher gained other insights which were sometimes more useful to the mentoring than to the research.

My position as researcher had been established with the new graduates and the other three mentors from the inception of the project; this meant there were no obvious difficulties in my interviewing the new graduates or the other mentors. In order to include my own perspective as a mentor, an independent interviewer with content knowledge about mentoring interviewed me twice, once before and once during the project and an academic unrelated to the project interviewed me at the end of the mentoring year.

In the month before the first interviews, the participants were sent information and consent forms (Appendices 3 - 6). The consent form sought consent for four interviews during the year but this was subsequently reduced to three. There was a slight variation between the information sheets for the mentors and those for the new graduates (or as they were then called "mentored midwives" – the

subsequent renaming change was made to highlight the fact that this project was about mentoring new graduates, rather than mentoring at another career stage). Five new graduates are mentioned on the information sheet; this number was reduced to four when one student left the university before completing her degree, but after the information and consent forms had been sent out. At the start of the first interview, I gave interviewees the opportunity to ask questions about the forms before asking them to sign the consent form.

Individual participants were interviewed separately, apart from one occasion when, at their request, two new graduates were interviewed jointly for their second interview. The interviewees were all contacted to find a suitable time and place where they would be free to talk openly and privately. The interviews were thus held at a time and place which suited the interviewee. The researcher generally arrived before the interviewee, and set up and double checked that the two recorders (audiotapes initially, subsequently one tape and one digital recorder) were ready. When the interviewee arrived she was welcomed, given a glass of water, asked whether the environment and room temperature was suitable and invited to indicate if this changed during the interview. The three interviews were semi-structured around the prompting questions are listed in Appendix D. The interviews were transcribed verbatim and sent by email to each participant for review and comment, in order to verify their accuracy and to provide an opportunity for any additional reflection on their content.

The first interviews were held in either a room at the university or an office at the local tertiary hospital. These were preparatory interviews to explore what each

participant understood and expected of mentoring. The atmosphere was soon relaxed and the conversations proceeded quite naturally. As the conversation developed, prompt questions were asked about other experiences of mentoring as either a mentor or a mentee. The semi-structured questions for all the participants revolved around their hopes and fears, their vision of the year ahead, and what personal attributes each believed they offered to a group. The phrases used to elicit further comment were "that's interesting" or "good" or "hmm", to encourage rather than interrupt the flow of conversation. At other times the meaning of what was said could have been interpreted in various ways, so the words or phrases were repeated or reworded to achieve clarifying comments. Concerns that were expressed overtly or, in some instances, covertly were picked up and queried by the researcher. There were times when the planned arrangements for the year were discussed, particularly in terms of what mentoring could realistically offer the new graduates.

By the time of the second interview, everyone knew each other well. The new graduates mostly chose to visit the researcher in her home a little out of town, while the mentors chose their homes or offices. The second interview took place half way through the year, after 16 group meetings had occurred. The participants were comfortable with each other and with the process by that time. The researcher was able to explore how the interviewee was finding the mentoring process and how the experience compared to their expectations. The first prompt question for the graduates was "Tell me about your first few months of being a midwife?" In an effort to find out what they thought they had learned, new graduates were asked what they had learned that was new and unexpected. Another question asked was

about how helpful each on-call mentor had been when they were called; interviewees were invited to make a value judgement about the helpfulness of the mentor on a 4-point scale, where 1 was poor and 4 was excellent. The mentors, by contrast, were asked whether concerns brought up in the first interview were still an issue or not. The mentors met only once as a group in the first six months, and they were asked if they thought meetings should take place more often. This middle interview acted as a sounding board for each participant's individual experiences of mentoring.

The third interviews were likewise at places and times which suited the interviewees; most were after the mentoring meetings at the home of one of the new graduates where the mentoring group regularly met for meetings. One mentor was interviewed before a dinner at the home of one of the mentors. In each case the venues were made as private as possible. The questions asked at this interview sought to discover what kind of support from among those offered, the new graduates found most helpful. The associated questions sought to discover why this was the case, what they had learned about midwifery and mentoring, and what they would change if this model were to be used for other new graduates. The mentors were asked about their experience of the group mentoring.

As part of the interview, each mentee was also asked to complete a 10-point visual analogue scale of confidence. The visual analogue scale is used "…to assess and monitor self-report measures in adults and children, in particular [of] fear and pain" particularly by dentists (Chapman & Kirby-Turner, 2002, p. 447). The scale is simply a horizontal line which is clearly marked with equal sub-divisions from one

to 10 similar to a "likert-type scale". A visual analogue scale is an instrument that attempts "to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured" (Gould, Kelly, Goldstone, & Gammon, 2001, p. 706). The mentee was asked to a place a mark on the scale that indicated their level of confidence in their clinical practice.

On the scale the lowest number (1) corresponded to: "feeling totally confident that I can handle any practice/clinical/ethical/legal/political situation that I find myself in, and in any location" and the highest (10) corresponded to: "the most scared/worried I can be, so scared/worried I want to run away" (i.e. panic). Participants were asked to indicate what mark indicated their feeling of comfort with practice at the present time (Chapman & Kirby-Turner, 2002, p. 450). At the second interview the mentees marked how they remembered their level of confidence before they began working as registered midwives six months beforehand and their present sense of confidence. At the last and third interview, they marked the scale again, relative to their feelings of ease with their current practice.

On-call and Face-to-face Contacts

The call logs provided the data source for telephone and face-to-contact between mentors and new graduate midwives. The logs were kept by the mentors who were on call, and included the following: date and time of contact, length of contact, type of contact (phone, text, meeting new graduate, meeting new graduate and client), name of graduate and a "value score". The value scores made by the mentors were to gauge their sense of the conversation and how well each mentor thought the

communication process went; for example, whether what the mentor said met the new graduates' concerns and her reason for contacting the mentor. A call log template was provided in hard copy and as a computer file to the mentors. They recorded the contact they had either with the new graduates or on a couple of occasions when they had sought advice from another mentor. The templates were mostly sent to the researcher as an attachment on an email or a hard copy was given to her at a group meeting. (The template and the legend provided to explain the intentions of the data collection shown in Appendix E).

Data Analyses: Thematic and statistical data

The various sources of data, such as group meetings, individual interviews, including the visual analogue scores for new graduates, and the logs of on-call contact, were broadly divided into two. Thematic analysis was used for the transcripts of meetings, interviews, and simple descriptive statistical analysis (frequencies and percentages) was used for the other data. Both forms thematic analysis were inductive, though the meeting data was subject to a greater depth of analysis, and therefore greater interpretation, than the interview data.

The visual analogue scales of confidence and the mentor log of contacts were collated statistically. The visual analogue scores were presented as a graph comparing the new graduates' perceptions of fear and/or confidence at three points during the year: prior to the start of practice (retrospective), at the midway point, and at the end of the year. The mentor call logs were analysed by counting the number of calls, determining how many of those calls resulted in face-to-face meetings, and the

reasons given for all 85 calls made to the mentors. How each of the data sources were analysed is discussed below, beginning with the thematic analysis of the group meeting data, which was more in-depth than the remainder of the data set.

Thematic analysis of the group meetings

The process of thematic analysis was undertaken using an iterative process of discovering points of interest inductively and intuitively, both despite and because of the researcher's insider position. The first step in the thematic analysis was to scan the meeting transcripts for the unexpected or interesting. The exploration of the transcripts was necessarily focused on the words of individuals, but it was the content expressed by that contribution which was of interest in the analysis. The individual contributions were analysed according to whether they were made by a new graduate or a mentor as well as identifying differences between individuals within the two groups. Each new graduate (NG1-4) or mentor (M1-4) is discussed as a representative of their group, rather than as particular individuals. Therefore the analysis did not focus on individual psychology or motivations, but instead looked at how new graduates responded as a group.

There were two phases to the meetings transcript analysis. The first phase focused on the new graduates' concerns – "where" they were in practice, "what" they were about, "why" they were presented, and whether this changed over the year. I first immersed myself in the transcripts to get a sense of common themes or assumptions. Using NVivo 8, I then coded passages of the transcripts into themes. This first phase which concerned the new graduates only, took place in two stages.

The first phase of analysis began by using a sample of six meetings spread equally across the year (1st, 9th, 14th, 20th, 25th and 29th). Each query, in turn, needed to be assessed for its thematic content, and for its similarity to previously analysed queries. By an iterative process of naming and refining categories, all of the queries were coded into one of ten categories, with each "reading" guided by findings from the previous one. I then re-read the transcripts and classified them according to five themes. The themes about "where" in practice the concerns lay included working environment, group culture, professional culture, clinical issues and administrative issues. This initial stepping stone paved the way for digging deeper into the content of the concerns brought to the meetings by the new graduates.

The next level of phase one progressed from naming a theme from single quotes about where concerns lay within the scope of a midwife's practice to exploring threads of meeting discussion from new graduates and mentors. In order to have enough material to work with, a further five meetings (13th, 22nd, 24th, 26th and 27th) were added to the original sample of six meetings. Interesting threads of discussion were collected using NVivo 8, and in time ten sub-themes emerged from 95 such threads. The iterative process continued until, using paper and coloured pens, the ten sub-themes were analysed into three broad themes.

The second phase of the analysis looked at the responses that the mentors made to the issues that were offered for discussion by new graduates. Another nine meeting transcripts were added to the meeting sample. This was to obtain an understanding of what responses were made, and whether these brought new insights into learning about the process of mentoring new graduates.

Thematic analysis of the interviews

The analysis of the interviews focused on presenting a broad account of the new graduates' year, as close to their experience as possible, using their words. This was done by collating a list of coded categories, and cutting and pasting each segment of transcribed data into the categories from each of the participants, whether new graduates or mentors, depending on the category. This was done by hand, using large sheets of paper onto which the segments of transcript were affixed under particular headings. The categories of themes changed over time as a result of the decision to foreground the mentoring meetings. The thematic changes made were done to increase the breadth of information about the group mentoring year.

This overview is intended as a backdrop to the analysis of the group meetings. Patterns of themes were matched across the data set within individual interviews over time, and between different individuals. The coding began by treating the participants' answers to the interview questions as the first step; but after a number of readings and iterations, new insights built up a story of the new graduates' transition process. The analysis of the transcripts showed what the graduates' difficulties were, how they managed these, what changes they observed, and how they used the system for support. The interview analysis began before the meeting analysis and was re-visited again after the meeting analysis. These periods away from the data allowed the researcher time to reflect and be clear about what was being investigated and why (Britten, Jones, Murphy, & Stacy, 1995).

The analysis of the Visual Analogue Scale of Confidence is included as the new graduates' marked the scale as part of the second and third interview process. Each visual analogue scale was anonymised and then comparisons were made between the individual scores to check whether a pattern had emerged. The results were collated and graphed and are presented in the findings. Where appropriate, other findings (call log data and practice outcome data) from the whole data set are integrated alongside the interview analysis to add richness to the description of the overall research.

The mentor interviews were coded until insights were developed about the challenges and responsibilities of mentoring. The findings are shared in the discussion chapter.

Analysis of mentoring call logs

The information from the call logs was recorded by the researcher onto an Excel spread sheet. Cross tabulations of the data were made to examine relationships between the date and time of contact, length of contact, type of contact (phone, text, meeting new graduate, meeting new graduate and client), individual new graduate and individual mentor. No attempt was made to formally analyse the call logs for statistical significance. A graph was developed from an analysis of the type and frequency of calls (85) and is presented in Chapter Four, (Figure 2).

The reasons given for the calls were logged by the mentors. These were allocated to categories and are presented in Table 5 in Chapter Four. The mentors also gave 4 - point value scores (poor, fair, good or very good) for how well each

mentor thought the communication went, and whether they thought the new graduates' concerns were met. These are analysed, using simple descriptive analysis, into percentages.

Ethics

A number of ethical concerns needed to be considered and managed in this project, prior to the granting of ethical approval by Victoria University of Wellington Human Ethics Committee. The major issue was that as researcher, I was both a mentor and an integral part of the mentoring group. This meant there was the potential for a conflict of interests to occur that needed to be managed. I needed to ensure that the research participants (mentees and mentors) did not feel coerced into participating in the project. It was also important that the new graduates understood that they were free to withdraw their consent to participate at any time without penalty. Participation in the mentoring group was assured and a commitment was made that this would continue as agreed, whether or not the new graduates agreed to participate in the research or later withdrew their support during the project.

We had also made a commitment to provide mentoring for a year, but this was to be at the active request of the new graduates, and not because the mentors thought it necessary. I therefore needed to put safeguards in place to ensure that my interests did not drive the mentoring interactions and instead left the active role with the new graduates, rather than with the researcher or the mentors. This philosophical approach to implementing mentoring mitigated against conflict based on power relationships, but conflict resolution systems were put in place to manage any

significant breakdown in the relationships. Finally, all comments and data were carefully anonymised to conceal the identity of the participants. This study is from a regional midwifery community where the participants are well known; therefore in order to protect their individual identities, part of the contracted agreement was that individuals could not be identified within the data or findings.

At each stage of the design, such as planning, data collection, analysis and discussion, ethical considerations played a part in what was appropriate and in some cases desirable to include, and what to leave aside, based on concern for the participants and the research process. All transcription was undertaken either by the researcher, or by someone who had signed a confidentiality agreement (Appendix C). The hard copies of the transcripts were kept in a locked cabinet in my home and on my personal computer as agreed in the ethics application. The digital meeting recordings were similarly kept on the personal computer, and the audiotapes were locked with the hard copies of the transcripts. The ethics in relation to the analysis of the data set began with checking and re-checking that the data was accurate. This checking entailed re-listening to the digital tapes of interviews and of the meetings to ensure the transcriptions were as accurate as possible, particularly in terms of quotes from participants. Accuracy is one part of ensuring ethical research and introduces my approach to ensuring the rigour and trustworthiness of this research.

 Section Three: Rigour and Trustworthiness

In this research there were some processes built-in to the research, and others external to the research itself, which acted to reinforce the accuracy and creditability

of the findings at different points in the analysis process (Guba & Lincoln, 1981, 1982; Hammersley, 1992; Lincoln & Guba, 1985; Morse, Barrett, Mayan, Olson, & Spiers, 2002). This seems to best fit the pragmatic approach taken in this research and the use of a mix of methods.

Member checking was used to test for credibility after each series of interviews. The interviews were sent to the participants to read and edit. With the exception of one participant who requested small changes, the others all responded that the transcripts seemed an accurate representation of their interviews (Lennox, 2006).

Descriptive validity was increased by presenting the new graduates' experience using their words and by using a low inference approach to the analysis of the interviews (Sandelowski, 2000, p. 336). This separation of analysis and interpretation has been clearly described in the methods above; it does not mean there was no interpretation, but merely that, where possible, the interpretation is either made in the discussion chapter or made explicit in comments associated with the quotations within the themes identified.

The process of collecting and analysing the data relies on accuracy and is crucial to claims of trustworthiness and rigour. In the initial stages of analysing the meeting data, the themes from the first five meetings were checked against a sample of six meeting transcripts representative of those recorded throughout the year. Although some changes in the frequency of particular themes were found, the themes remained constant throughout the year. This sample check occurred again

when the size of the representative meeting sample was doubled later in the analysis.

This data, too, reconfirmed the direction of the analysis. As findings were reinforced

rather than changed by increasing the representative sample of meeting transcripts,

the accuracy of the analysis up until that point was seen to be confirmed. This

theoretical validating process of "making the case for analytic and re-presentation

techniques developed in the study" was therefore used twice in the analysis of the

meeting transcripts (Sandelowski & Barroso, 2003, p. 806). This is important

because it supports the researcher's constructions or interpretations of the "facts"

and the procedures for producing an interpretative synthesis.

A reflexive account of my participation

Who I am affects the account I have given and what I considered important to the

research process and outcome analysis. My history as a midwife and identification

with the aims of the home birth movement, and the autonomy of individual birthing

women affects my attitudes to sharing knowledge and power. This history, together

with working as an educator, influenced the approach taken in this research, where

my intention was to observe rather than influence the direction of the project as a

researcher. Throughout the project, the research data was collected non-intrusively

and voluntarily, as it was important to reduce any activity which was self-serving for

the research.

In one situation there was a conflict between the research and the intention to

be non-intrusive and directed by the new graduates' consciously determined needs.

A suggestion I made early in the project was that the new graduates write down the

practice stories they told at the weekly meetings, and use them in their practice portfolios. These reflections, if used in conjunction with the Standards of Practice, would have prepared the new graduates for their Midwifery Standards Reviews (New Zealand College of Midwives, 2005). Reflections were needed as part of the requirement for that review at the end of their first year. These may also have provided some interesting case studies for the research about their experiences and in their own words. The new graduates thought the idea a good one but, in the event, they were not interested in writing their reflections. Though a few stories were collected, these were stilted and done to satisfy me, rather than to fulfil their own needs, and were therefore not used. The idea was dropped because it was seen to contradict the intention to be non-intrusive and allow the mentoring process to unfold naturally.

The role of the conscious assumptions written prior to the commencement of the project may have had some effect on the mentoring process but not on the research analysis. I was conscious, as were the other mentors, of encouraging collaborative interprofessional and intraprofessional conversations; this was the second of the ten conscious assumptions outlined in Table 4 (p. 83). This awareness entailed professional values accepted by all four mentors such as being honest, transparent and having the woman's best interests in mind.

The fourth assumption, about different mentor approaches encouraging flexibility in the new graduates, was identified by the new graduates in their interviews as a positive feature of the meetings. This assumption may have influenced the behaviour of the mentors including me to the extent that rule-driven

suggestions by mentors within the meetings were regularly challenged by other mentors. One particular episode involved a question by a new graduate who wanted to know what was expected of her about following up women after a miscarriage. This question led to a mild mentor disagreement about how available one should be to women and what was minimally required. As a researcher, during the analysis of the meeting dialogue, I found that all four mentors were capable of being dogmatic, of blocking conversations, and of other negative behaviours – none of us were exempt.

The seventh and eighth assumption related to the critique and use of evidence; but in the event, it was the hospital guidelines, rather than the actual evidence, which were more commonly sought and discussed in the mentoring meetings. I brought articles to meetings early on in the year, but this practice waned as the interests of the new graduates were much more obviously practice focused. My conscious assumptions may have played some small part in my mentoring behaviour, and this may have shaped the project a little, but not the research. At least the influence was only to the extent that they comprise values and beliefs that I hold anyway, and in this way they may have influenced my analysis and writing.

I kept a journal where I wrote my observations on the meetings and about the mentoring project in general. Initially I understood my role as researcher would be a leading one; I would create agendas, communicate with the group and arrange the on-call mentor roster, doing all that was required for keeping the project going. On reflection, given the non-intrusive philosophy behind the mentoring and the "naturalistic design" which was developed, I realised that as a researcher I needed to

step back, rather than intrude on the mentoring process. This mostly non-intrusive approach left the way open for me to participate as a practitioner and mentor alongside my colleagues. At times I was completely a participant, and at others, away from the action, I was the researcher.

My researcher self was as observer on the perimeter of the project. A naturalistic inquiry is "always a matter of degrees", however and this study was no exception (Patton, 1990, p. 59). As a researcher, I found not knowing where the final analysis would focus was challenging. The opportunity did provide me with the possibility of finding points of connection between the quantitative and qualitative approaches, regarding the knowledge to be produced and the methods by which the data were collected (Morgan, 2007, p. 75). The meetings which ultimately became the focus of the thesis did so only after the new graduates' final interviews; and up until that time, there were many other potential foci.

As a participant and observer researcher, I learned about how other experienced practitioners saw their role and on what they based their clinical judgements, and I found this a fascinating revelation. My own experience, interests and perspective were more grounded in the individual experiences of childbearing women within the community, rather than working in and with the hospital system, which was more the case for the other mentors. Although I have worked in and accessed hospital services, my beliefs about birth are more focused on women taking charge of their own process and avoiding the medicalised hospital environment; the other mentors' perspectives therefore added valuable comprehensiveness to the new graduates' socialisation.

Summary

In this chapter the study design has been described in three sections, beginning with the theoretical background to the study and why a pragmatic, exploratory and descriptive framework was developed. The data collection strategy and methods outlined in Section Two whilst pragmatic, dynamic and responsive to the practice environment, had a framework of aims and assumptions which have been outlined. The integrated qualitative and quantitative data collection strategy has been described and the sources of data outlined. The methods of data analysis – meeting transcripts, interviews within which confidence analogue scales were recorded, on-call and face-to-face contact logs – are outlined for each of the data sources.

There were ethical concerns about the mentoring arrangement. The vulnerability of the new graduates within the mentoring group was discussed and addressed within the ethics application (Appendix F) and throughout the research process. The rigour and trustworthiness of the research has been discussed in Section Three, as well as the researcher's reflexive account of her participation. Finally, my position in the research has been presented, including a negative case, which is included as evidence of integrity.

The first of two findings chapters follows, beginning with the descriptive analysis of the call logs of contacts, the thematic analysis of the new graduates' interviews with the visual analogue scores embedded, and the thematic analysis of the mentor interviews. In their final interview the new graduates were asked what particular form of support worked best for them, among the range of support forms

offered over the year. They overwhelmingly chose the group meetings. This then became the beginning point and focus of the data analysis and findings described in the second findings chapter. I have taken a low inference descriptive approach to the whole data set, as advised by Sandelowski (2000), and have left the in-depth interpretation of the richly descriptive data to the final discussion chapter.

IV.   FINDINGS 1: WHAT WAS DONE AND WHAT WAS SAID

Introduction

This chapter presents evidence about the year: how the group mentoring model

operated – in particular the number and type of one-to-one contacts between new

graduates and mentors; what both the new graduates and the mentors said about the

model; and how the new graduates perceived their confidence developing. It

presents findings from several data sources: the logs kept by mentors of their

individual contacts with new graduates, interviews with new graduates, including

visual analogue scales of how confident they felt, and interviews with mentors.

A key finding from both the new graduates and the mentors was that the

group meetings were considered to be the most important part of the group

mentoring model. These meetings were recorded, transcribed and analysed, and the

findings from the analysis are the subject of the next chapter.

Contacts between New Graduates and Mentors

This section describes the contacts that occurred outside the group meetings.

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.

During the year, mentors recorded 85 contacts with new graduates: 56

contacts (66%) were phone calls, 5 (6%) were text messages, on 8 occasions (9%)

the mentor and midwife met without seeing the client, and on 16 occasions (19%)

they met together with the client.

As shown in Figure 2 most 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).

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
☐ Met midwife	1	1	4	1				1				
☐ Met midwife & client		2	10	1		2	1					
▨ Text			4		1							
■ Phone	2	10	10	6	12	9	1	3	2	1		
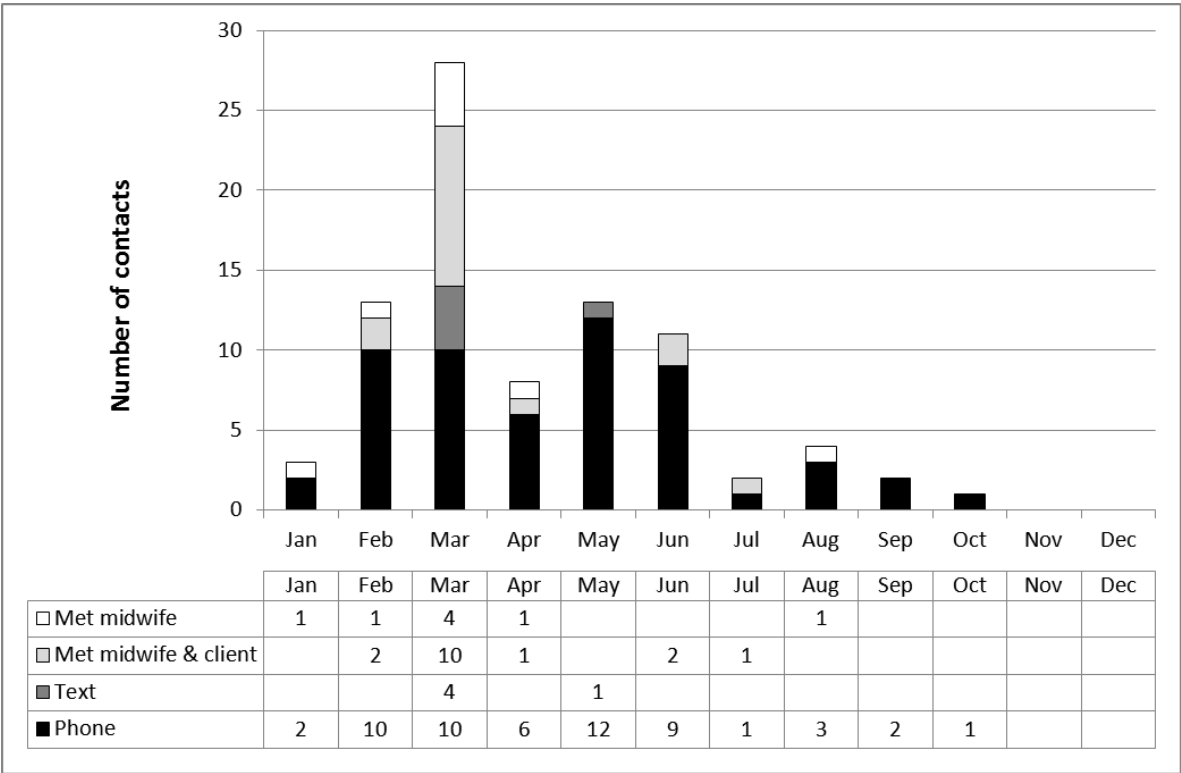
Figure 2: Number, type and frequency of contacts between mentors and new graduates over
one year

Of the total number of calls, 46% were generated by one of the four new graduates, two others generated 20% each, and one of them generated only 2%, while 8% involved more than one new graduate. While the new graduate who generated most contacts had twice as many phone contacts as the other two, she met with a mentor less often.

Two of the mentors had a total of 27 contacts, one had 20, and one had only 11. One mentor had 10 contacts involving meeting with the new graduate (with or without her client), another had 9 meetings, a third had 5 and one mentor had only had 1 such contact.

Mentors gave a value score on a 4-point scale (poor, fair, good or very good) to each contact. No contact was scored as poor, 16 (19%) were scored fair, 48 (56%) good, and 20 (24%) very good. Analysis of these scores shows considerable variation between mentors in how they scored the contacts. For example, one mentor scored 48% of contacts as very good, while another scored 40% fair, 40% good and 20% very good. The criteria for the different scores were not defined, and this degree of variation suggests that there was little consistency in how they were applied. These value scores have not been analysed any further.

Mentors recorded a brief description of the reason for the contact. These descriptions were found to fall into one of 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.

Table 5 shows the distribution of these different kinds of requests over the course of the year. It is of interest that five of the nine calls in the second half of the year involved a new graduate discussing an issue without seeking advice or assistance.

Table 5: Reasons new graduates contacted mentors over the year

Month	Advice	Assistance	Giving information	Discussion	Mentor initiated
January	3				
February	5	4	3	1	
March	4	12	11		1
April	6	2			
May	6	1	3	3	
June	7	3	1		
July		1		1	
August	2			2	
September	1			1	
October				1	
November					
December					
Total	**34 (40%)**	**23 (27%)**	**18 (21%)**	**9 (11%)**	**1 (1%)**

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 assistance. 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.

The next two sections present the thematic analysis of interviews with new graduates and mentors. These analyses help to put the new graduate/mentor contacts into the broader context of the whole group mentoring year and the new graduates' developing confidence.

Thematic Analysis of New Graduate Interviews

Each new graduate was interviewed three times during the year to explore their expectations, thoughts and experiences. Analysis of the interview transcripts identified four common themes, discussed below under the following headings:

- responsible professionals who seek the support they need

- midwife moments: reaching milestones

- jumping hurdles and gaining confidence

- weekly meetings: a rich source of learning and support.

Each theme is illustrated by quotes from the interviews. In these quotes and in the later quotes from mentor interviews, speakers are identified by whether they are a new graduate (NG) or a mentor (M), and individuals within each group are

numbered 1 - 4. The interview in which the dialogue occurred is denoted by whether

it was the first, second or third interview, for example, "NG1, 1st Interview."

Responsible Professionals who seek the Support they need

Even before they graduated and became registered, it was clear from their first

interviews (prior to registration) that although the soon-to-be new graduates saw the

mentors' experience as potentially helpful, they also saw themselves, once

registered, as competent, responsible professionals. They 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).

These first interviews showed that 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 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, they knew that there were aspects of practice to which they were blind as students, such as how it felt to be on a pager and to be fully responsible for their own caseload. The words below clearly articulate these thoughts:

> 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. They did not want or expect the mentors to be at births with them unless they called them, and understood that mentors would be unlikely to be with them if an unexpected emergency occurred, but that the mentors' role in this situation was one of debriefing and support following the event. This quote gives expression to a vision of the mentors' role:

> 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 I 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 soon-to-be new graduate midwives were asked what they thought was the role

of the mentors. One said that the mentor's role was a guide to her in all she had to

learn about being in practice; another spoke of the mentor as a sounding board with

whom she might check out her ideas and have practice decisions challenged. The

first view is a broad brush notion about the mentors' role, whereas the second view

is clearer and more specific:

> With me, mentoring is being supported by an experienced midwife really just
>
> helping guide me into my venture into independent midwifery practice and
>
> really guiding me in all I need to know about being in practice that you don't
>
> get from being a student. (NG3, 1st Interview)

> Mentoring? Well I understand it as a beginning practitioner that I will be,
>
> that the mentor will be – what's the best way to put it – someone to, someone
>
> not teaching me but someone to bounce ideas off and challenge me about my
>
> thought processes and my decision making processes. (NG2, 1st Interview)

This new graduate wanted her thinking to be critically reviewed in order for her to

understand her midwifery role more clearly. Mentoring was seen as providing an

accessible and experienced practitioner support system 24/7, where listening and

challenging was an integral part of the process. This facility to call a mentor at any

time was emphasised throughout the first interviews of the soon-to-be new

graduates. They felt this contact would offer 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 was 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" provided them with the reassurance they needed, 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 for 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 you were available if [needed] to actually be physically present. (NG1, 3rd Interview)

Another new graduate, who was clear in the first interview that the mentor was important as "someone to bounce ideas off and challenge me", maintained her opinion that the mentoring was important for her entering self-employed practice:

> It's been great I wouldn't want to begin independent, you know, community midwifery, self-employed midwifery, without it [mentoring]. (NG2, 2nd 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)

The new graduates were concerned at the beginning of the project about how they might be viewed when they called the on-call mentor. Their concern was that by showing a lack of knowledge about aspects of practice that they should already know, they might alienate the support of their mentors:

> And at the beginning I thought am I just able to ring? And I don't want to ask stupid questions because that's what I felt…and they are going to look down on me and say "oh my God how in the hell did she graduate"?! you know that's where I was at. But now I don't feel like that. I felt like [the mentors] have been very supportive, everyone's been great. (NG1, 3rd Interview)

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 it appears from the interviews that the new graduates

began to discriminate when, and whether to call and who was appropriate in this instance (new graduate peer, mentor or obstetric registrar). 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 [the need for] 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 new graduates. Their group of four was an important source of support and strength to one another throughout the year. 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 phoning in her right 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 others, then, is a key developmental capacity, but knowing whom, 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 obstetricians and registrars 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 obstetricians or registrars 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 intra-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 [a cephalic malformation] – 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.

New graduates varied in the extent to which they used the mentors for questions or assistance over the year, as reported above, where the mentor logs are analysed. During the second interview, each new graduate was asked to score the extent to which the mentors' responses to calls met their needs. On a 5-point scale from 0 to 4 (where 0 was not at all and 4 was excellent), all new graduates responded with a score of 4 apart from one new graduate's experience with one mentor. This experience, although not typical, raises some important issues and is discussed further below.

This new graduate found one particular mentor more difficult to ask for help than others, but she was quick to reassure me in the interviews that, had she needed to ask for help from that mentor, she would have done so. Interestingly, at the last interview it became clear to her that the issue was her lack of confidence in asking for what she wanted, rather than that the mentor was not prepared to come when called. As she reflected:

> But I think at the end of the day if it was a big problem I would have rung you know, I would have, it wasn't going to influence that. So I don't want you thinking that I wasn't going to …. (NG1, 3rd Interview)

This new graduate went on in the interview to provide an example of calling that particular mentor:

> Oh I had to and I felt like I just needed somebody there and it was like, "yep I'll come" "do you want me to come", she actually said "do you want me to come" and I said "yes I do, I want you here". And she said "okay I'll be there shortly" and that's probably her personality I have to say that. And that's it and I didn't know that earlier on and if I'd known that maybe I would have just said well actually no, I can't deal with this and I need you here and that's what I should have said. But later on it was down the track you know and I said no I need you to be here, can you come. And she came. (NG1, 3rd Interview)

For this new graduate, early in the mentoring year, she felt that when mentors were called they needed to come if asked, and not question the reasons. She thought it was up to the mentor to ask whether face-to-face support was needed, because asking assertively for a mentor to come took more confidence than she had at the beginning of the year. As she reflected strongly:

> It felt like I needed her to say to me "do you want me there?" and I would have said "yes" but she didn't say that and I felt I couldn't ask. Okay but later on when I got more confident she said "oh well something or other," I said "no actually I need you here" and she went "okay that's fine". And she was probably willing to do it back then but I didn't ask for her. I think that's one thing that maybe the people who are being mentored are maybe a little

bit more hesitant in asking and maybe the mentors have to say "are you okay" and "do you want me there or do you want me to do something"? (NG1, 3rd Interview)

This issue was not identified within the data for other new graduates. This issue was exposed because each new graduate deserves mentoring appropriate to her needs, and in this case the graduate believed it was her lack of confidence that limited her ability to call. Interestingly as she gained confidence in practice, she increased her capacity to ask assertively for help.

Other developmental changes the new graduates made over the year were reflected in their stories of reaching milestones and meeting challenges sometimes quite assertively. They all had diverse responses to the significant stresses in their first year. These are shown in the following section, where the second theme is explored.

"Midwife Moments": Reaching Milestones, Jumping Hurdles and Gaining Confidence

In the interviews, it was striking how much difference there was in the way each new graduate experienced the beginning months of their first year. The interviews suggest that their clinical and cultural experiences played some part. Whereas two of the new graduates were thrown very early into the stark reality of managing an obstetrical emergency, the other two had different and somewhat gentler introductions to confronting the full measure of their professional responsibility. As the year progressed, the interviews show their confidence developing as milestones

are reached through what one new graduate called multiple "midwife moments".
These moments contained both reassuring and challenging experiences, and
mentoring appears to have played a role in facilitating the new graduates' sense of
confidence. Another often overlooked but important source of confidence building
for new graduates came from attending childbearing women, particularly in labour.
One new graduate described how she saw herself as a student for some time before
acknowledging to herself that she was a midwife:

> [It] wasn't like a bolt out of the blue it was gradual and you realise it's yours
> and the woman's responsibility … I found it wasn't a sudden transition from
> student to midwife I saw myself as a student for quite a while. (NG2, 2nd
> Interview)

Prior to beginning practice, some new graduates were feeling apprehensive but
confident, whereas others began apprehensively and took longer to feel comfortable.
One described how surprised she was that the process of becoming comfortable as a
midwife was natural, despite her early apprehensions. She gained her reassurance
from the women for whom she cared:

> I feel like I have actually become, even though I am not like "confident"
> confident, I feel like I have become a lot more, I have become fairly
> comfortable more quickly than I expected. I feel like at the beginning I was
> not really sure of where I was at in terms of my abilities because I hadn't
> been a midwife yet so I felt all that apprehension and how was I going to be
> and am I going to be able to do this and deal with the situations? Have

women trust me to be with them and trust me to guide them through…and

you know it all felt like it all happened fairly naturally and so that's just kind

of progressed on from there, really well. (NG3, 2nd Interview)

Another new graduate reflected on her experience of the first three months in practice as being like a "big black cloud", as the calls to attend women in labour became more frequent. She found the experience very scary and said she wanted someone there to hold her hand. It was a mentor's words during this period of time that gave the effect of hand holding, by providing her with much needed reassurance during a particularly dark time. She was reassured that her knowledge base was good and that she could trust her competence:

A big black cloud really, it was, I was constantly in this fear you know it was

well yeah I was even fear[ful] for the births. Somebody would ring me and I

wasn't joyous about them having a birth, I was thinking, oh my God what is

going to go wrong. That's what it was like, oh I wish somebody was there to

hold my hand but that was ridiculous because you know as [a mentor] said to

me, "well you've actually passed, you've got the knowledge so you've just

got to apply it, you can do it", and she was right and I kept on thinking about

this the whole time. (NG1, 3rd Interview)

Despite having the knowledge and managing an emergency situation early in practice, the experience of confronting the potential for death to occur within practice coloured the transition for two of the new graduates. One of these described her learning occurring in what she called "midwife moments", for example, when

she faced an obstetrical emergency during the second birth she attended. She successfully managed a shoulder dystocia (where the head is born but the baby's shoulders are stuck behind the pubic arch), followed by an intense newborn resuscitation. She reflected, "…that wasn't a good midwife moment but it was a midwife moment." The repercussions of this experience she says were:

> …very big for a long time and for a while there I was this close, just thinking I can't do this, I can't wear that sort of responsibility … I don't think I ever understood it [the responsibility] until that point." (NG2, 2nd Interview)

Of course she knew babies and mothers died in childbirth, but understanding one's responsibility at a visceral level is quite different to knowing intellectually. Subsequently, whilst driving to her next home birth, she rang two of the mentors: "… I was a complete blithering wreck on my way to it and got talked through that by [mentor] and [mentor] and they were really supportive" (NG2, 2nd Interview).

When asked about the ways in which mentoring helped following this early obstetrical emergency, she responded by describing the experience of attending a meeting of the mentoring group within 24 hours of her experience: "…it was a safe outlet to say exactly what happened like we did at that debrief right afterwards that was really [helpful], I needed that" (NG2, 2nd Interview). In response to a question about how the debriefing was useful, she said: " …because I could basically spew forth what happened without considering what I was saying, just say it as it happened … I needed that" (NG2, 2nd Interview). This meeting was attended by the

whole group and was premised on listening and offering only supportive comments and not criticism.

Whilst experiencing new events and attending births is stressful as a new graduate, the most significant impact on these new graduates' lives was confronting criticism and humiliation at a hospital delivery suite. A meeting with delivery suite co-ordinators was called straight after a series of bullying experiences which one new graduate described as:

> …a very good move… up until that point…we had been "the new grads" and they [were] all kind of, "what's this, why are they being paired up and are they being mentored properly" and all this sort of stuff. (NG3, 2nd Interview)

The new graduates had felt belittled and humiliated for asking clinical questions of a unit co-ordinator. During one such interaction:

> …everybody stopped, it must have been the busiest day of the week and there were probably about twenty people in that delivery suite and they all stopped and turned and they all looked at me. (NG1, 3rd Interview)

For this midwife, looking back over the year:

> …that's my worst experience and such a little thing but that was my worst… to me that was just making me look really incompetent and I just felt like giving up that day it was just like no you can't do it. (NG1, 3rd Interview)

Interestingly, she had experienced an obstetrical emergency and managed it well, but for her this humiliation was "the worst" of experiences.

At a meeting held with hospital staff, mentors and new graduates, the mentoring philosophy was freely and frankly discussed. This marked a change in the hospital staff's relationship with the new graduates and one observed that: "Now every time I see one they smile, [and] there's good communication" (NG3, 2nd Interview). Apparently other LMCs working within the hospital subsequently commented to the new graduate that they were really surprised how well her group were accepted, and that they noticed staff "were so pleasant…when they were watching an interaction between us" (NG3, 2nd Interview). Although the mentors were an integral part of solving this conflict situation, the new graduates made the decision to have the meeting, and this new graduate participated in managing its resolution. The new graduates supported one another on a daily basis, and whenever one was affected by an issue, the others would be involved.

In the first six months the three new graduates accompanied one another by attending births together in pairs (not fixed pairs, any one would accompany another), and this proved important to their developing confidence. Sometime after this six-month milestone, when they had all attended 12 births (either as the named Lead Maternity Carer or as the back-up), they began going to hospital births alone, which was another developmental milestone (Lennox, 2006a). The fourth new graduate commenced in practice when work-ready, having healed a broken arm, and was mentored into practice by her colleagues. We met at her house for 20 of the 31 meetings and she participated in most of them, despite not actively practising in those early months (Lennox, 2006b). She barely used the mentor on-call facility because her now-experienced new graduate peers were able to support her. They

eased her transition into the hospital environment, where she was encouraged by their now well-established network of colleagues. This close knit peer group assisted in their achieving increasing confidence over the year by working in pairs and using the mentoring appropriately when needed. Over time, the new graduates had their ability to care effectively for women regularly reinforced, and they developed good working relationships within the hospital. The new graduates worked at achieving a comfortable balance between being interdependent and independent as midwives.

The expression "feeling like a midwife" was threaded through many of the new graduate interviews as their professional confidence grew throughout the year. It became clear from the interviews that the new graduates recognised they felt very much more confident as midwives at the end of the year than at the beginning. This feeling grew from experiences of success using their clinical skills and managing relationships with others. As various milestones were reached – the first births, the first of any particular intervention, including the first critical incident, all accumulated milestones – these were integrated and the new graduates' understanding of practice became more fully developed. This integration was facilitated by talking, reflecting and debriefing, but their sense of "feeling like a midwife" was rather like a barometer that rose and fell with events and experiences. As the new graduates gained a sense of their developing professional capacity, they talked less of feeling "like a fraud" and more about their achievements. In the beginning it was the successful performance of clinical skills that reinforced their sense of authenticity, as illustrated in the following quote:

> … that actually made me feel good when I got it [intravenous cannula] in on someone with bad veins. She did have crappy veins. I was thinking, "well at least if someone was bleeding at home at least I know I have done it before" so it gives you that little bit of confidence to do it again. (NG2, 2nd Interview)

When NG2 was asked what made the difference between the times she did or didn't insert an intravenous cannula successfully, she said; "…the times when I didn't get it in I had someone over my shoulder watching me" (NG2, 2nd Interview). There were other times, however, when she recognised that she found having someone there expanded her understanding of what was possible and appropriate as a midwife. For example, she reflected on learning about discriminating when interventions were indicated so that her clinical decision making capacity expanded:

> I need a little push and that's where I have found mentoring good… I needed that person to say it's ok to try and deal with what you get… don't close down judicious use of ARM [artificial rupture of membranes]. (NG2, 2nd Interview)

Learning when to follow rules and when a clinical scenario requires active decision making is an extremely important part of critical thinking for a midwife. Experience is certainly important for developing confidence, but it does take time. At the interview before beginning practice, one student expressed apprehension about her ability to be a midwife. By the second interview, when I enquired about whether her feelings of apprehension were still present, she said:

> …absolutely, I mean even just in my clinical skills and things like that. I hadn't done any suturing [as a student on a woman] until I … started [clinical practice] and you know, I am still tentative, but I am doing it. (NG4, 2nd Interview)

By the last interview, a new graduate expressed her awareness of "feeling like a midwife" as comfort with and familiarity with the working environment, including her friendly relationship with colleagues:

> When people ring me I go "oh this is great, excellent" and I get out there. You know I think that with just everything. Like not knowing where you were going, where things were at the hospital and, and you know now I've got a relationship with the hospital midwives now. It's like, I don't see them as the hospital midwives and me, I just see them as my absolute colleagues now. I go in there and have a wee chat. (NG1, 3rd Interview)

Working relationships are an extremely important aspect of feeling comfortable and safe, without the need to pretend or conceal concerns one might have about clients or about one's decision making. Earlier in the year, she had felt like a fraud; when she was asked about her sense of being a midwife at the second interview, she replied:

> I thought about this yesterday. Yesterday I had a couple that had just lost their baby at 10 weeks and I went round to see them and I didn't actually do anything but I was just with them. (NG1, 2nd Interview)

Clearly her confidence about being "with women" and not necessarily having "to do" anything indicated to her that she had transformed her sense of the role of a midwife and of her capacity to fulfil that role.

Jumping Hurdles and Gaining Confidence

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 3 indicates that after a five month period of mentoring, 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.
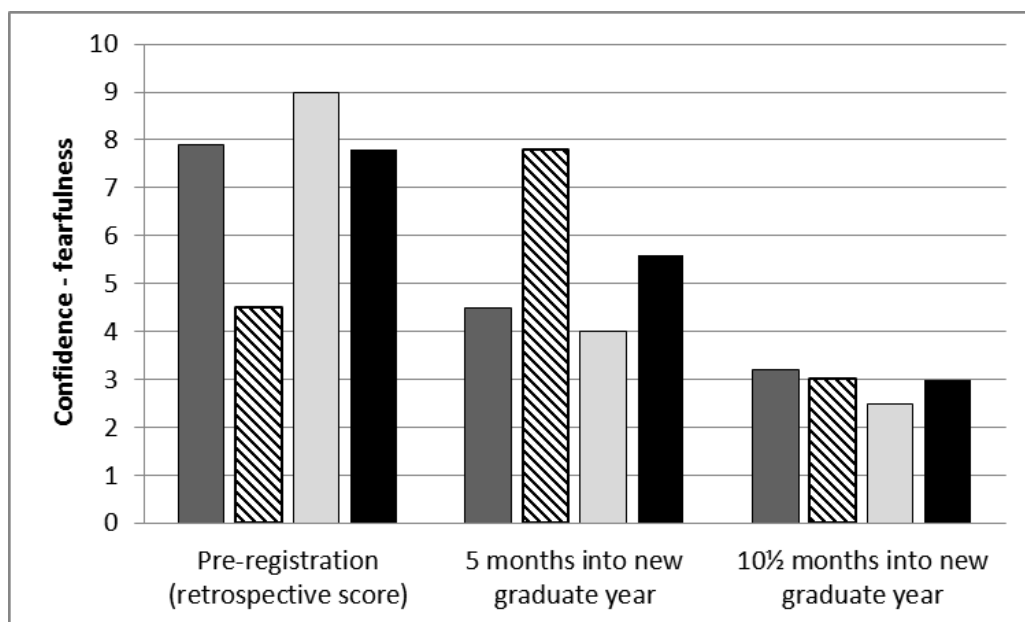
Figure 3: Visual analogue scores of the four new graduates over the mentoring year (from 1=confident to 10=fearful)

The new graduate shown by hatching was delayed for six months before she was able to start practice and scored herself as more fearful at the point that she started practice, compared to when she had been a student. The new graduates are not labelled with their number on this graph, because those who know the individuals involved would then be able to identify her throughout the thesis.

In the next section, the third theme identified in the analysis is presented. What emerged in this theme was a focus on the regular weekly meetings held between the new graduates and their mentors. The analysis is based on a combination of data derived from the new graduate interviews and from the interviews with the four mentors.

Weekly Meetings: a Rich Source of Learning and Support

The weekly meetings with all the new graduates and mentors were identified as a very significant part of mentoring. 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 the 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. This silent learning which occurred at the 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 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)

The mentors were acknowledged by the new graduates as a source of knowledge,

but also for their shared approaches to childbirth and also their different

perspectives:

You get lots of different things that you can use…I think having, because

you all come from the same place – as in the heart – the right place. You

have the emotional intelligence. You all have different experiences but you

> all come from that very firm "women can do it" [perspective/philosophy]. So
>
> when we have a "round the table" it's actually interesting getting different
>
> perspectives even if you guys actually have a little discussion around it.
>
> (NG3, 2nd Interview)

In the quote above the new graduate is referring to the debates between mentors as being useful learning, particularly because of the diversity of perspectives. The new graduates said that the group made them feel safe, and the fact that the mentors' perspectives were different was not a problem. The new graduates continued to use the mentors' experiences to unpack the different ways one might practise safely within a range of midwifery practice:

> I like the idea of lots of different, you know, four different approaches, four
>
> different strengths. I like that, it's different and you challenge each other as
>
> mentors let alone just us, so that's, I find that really cool. And it is challenge
>
> with love. (NG2, 2nd Interview)

This quote above is referring to the mentors challenging one another and not just the new graduates, which she found "really cool". It was the mentors' capacity to critique one another and the manner in which they did so that she enjoyed. The differences brought by the mentors' views and styles of practice were commented on and appreciated:

> Oh yes loved it because that, that's what it is, you know. These women
>
> [mentors] are different and I like that, it has actually worked well for me. I

think to be honest I can't think of anything I would want, want done differently. I think possibly the way it has worked.

Researcher question: And you've felt safe in the group?

In the group? [questioning tone] I always feel safe, always felt safe, always. (NG2, 3rd Interview)

The environment in the meeting created by mentors critiquing one another did not seem to create an unsafe environment for the new graduates. If anything, it appears to have added to the new graduates' understanding of practice and that taking responsibility meant taking their own thoughts and position seriously:

What I was just going to say was that because there are these different "positions". If everybody was the same I would probably feel more persuaded into being like that also but because there are different opinions it gives you more sort of responsibility to define what your own [position] is. (NG4, 2nd Interview)

This comment is about the value to the new graduate of being part of a group of new and experienced midwives where the mentors are able to safely model critiquing one another. It stimulated a sense of responsibility in her to define her own position instead of modelling on one mentor, which she had heard about from her colleagues. In some situations the new graduates have heard of their colleagues being intimidated by one-to-one relationships with a mentor:

I have heard from other people who have had one-on-one mentorships and that sometimes it is putting yourself out there to say what you really feel

> whereas I think we are actually ok about saying exactly what we feel whether we are afraid or whatever … everyone's really honest. I think it's really important because I think some people in one-on-one, just from talking to other people, is that they feel intimidated by the mentor who has had a lot of experience. I don't think we have that. (NG3, 2nd Interview)

Another comment about the value of the group meetings was that the new graduates in this group heard in-depth stories and feedback about the work of three other colleagues. Getting feedback at meetings was highly valued by the new graduates, who came even though they could have been up working for hours beforehand. They also came to the meetings to hear their colleagues' stories. The meetings provided the place where they got to know the mentors as people, as well as experienced professionals from whom they could learn. They came to almost all meetings and when they didn't come, it was generally because they were asleep following a birth or were attending a birth at the time. Of the 31 weekly meetings held, only ten meetings were missed by the new graduates; one missed one meeting, two missed two meetings and one missed five meetings (Lennox, 2006b).

> …everything that I have done so far has been a new experience, so it's really good to talk about that and share those stories. To reaffirm − "ok, this was normal and this wasn't normal and what could I have done here"? Getting feedback [was important]. And when we were talking to [mentor] I remember her talking [saying] about how to ask a woman what she's thinking right at the end [of a birth]. Things like that. (NG4, 2nd Interview)

This last comment uncovers the usefulness of having a group of midwives all talk about their ideas and experiences about childbirth within a structure which privileged the new graduates' stories. The primary purpose of the meetings was about ensuring the new graduates had the space to talk and that they would be listened to and treated kindly.

> It was good, the group thing. You know I felt like I could actually, I felt like I could actually store it all up because I didn't want to bother anybody but if I thought if it was a major thing I would have rung. But I thought I could store it up for that Monday and then just talk to everybody and just say "well this is what's happened with my week what do you guys think?" (NG1, 3rd Interview)

The new graduates used the meetings for learning about midwifery, but they also learned about mentoring and how groups can facilitate learning. When asked in the second interview about whether the meetings were serving their purpose or whether change would be helpful, one new graduate immediately registered concern:

> Changing it…I am not ready to change it. That's just me, I was thinking about that the other day, not so much the process but what happens when they stop mentoring us. (NG2, 2nd Interview)

The new graduates were often fielding conversations about how they found group mentoring, because the commonly understood model of mentoring was one-to-one.

> Yes, because it's been quite interesting actually because somebody asked about my mentors and I said it's been absolutely great this year. I love it.

> You know I gave them a run down on how it's all worked and it's just been
> so good and you know I'd recommend it to anybody sort of thing and they
> said "oh yeah you're part of that group that's been researched" so they know
> that is happening. (NG1, 3rd Interview)

Creating a safe environment was a process of getting to know one another, the new graduates learning to trust that the mentor support was actually forthcoming when needed, and the mentors exploring their role as the "responders" rather than the "initiators of contact". The active role worked well for the new graduates, who, in the uncertainty of their transition to practice, had a sense of being in control of how and when they were mentored.

The new graduates claimed that the meetings were the most important feature of all the forms of support offered by the mentors. In their last interviews, three of the new graduates were asked specifically "Of all the support such as the meetings, the 24/7 availability, being able to phone, have a mentor coming in, texting, what was most important of all this if you had to choose, even though you might like to keep all of those things, what was the most important thing?" Although all underlined the importance of the 24/7 on-call availability for a sense of security, particularly early in their year, the meetings were seen as the most important support for debriefing and on-going learning throughout the year, as illustrated in the following quotes from all four new graduates:

> But yeah, sort of March / April it was like, oh I couldn't wait to get to those
> meetings to actually say "well look I've got this, this and this. Have I done

this right, do you think this is good or what do you think about that" you know. (NG1, 3rd Interview)

Well, at the beginning it was the 24 hour seven days a week. I mean I have to admit it was knowing that you were available if, to actually be physically present. Now it is knowing I can ask for, not advice but just bounce things and sometimes I do that. And also know it's a, it's [the group meeting is] a safe forum to do it in. Yeah. I mean and, and to know that if I really stuffed [up], I would be told you know how to deal with that. (NG2, 3rd Interview)

 [In relation to the meetings] actually sitting back and watching has been a learning thing for me. [When pressed about whether if she had to choose only one form of support if the meetings were enough] No. It's the security of knowing that our mentors were there 24/7. (NG3, 3rd Interview)

I think the meetings. (NG4, 3rd Interview)

Overwhelmingly, during the end of the year interviews, the group meetings were seen by the new graduates as the most important form of support long term, though the 24/7 availability was also important in the first six months.

Summary of the Findings From the New Graduate Interviews

The preceding description provides the reader with a sense of the world of a new graduate midwife, their needs and apprehensions. Although new graduates see themselves as independent, responsible professionals, they thought it was essential that they had the assurance of oversight and support when they needed it from an

experienced mentor. The transition into practice takes courage in thinking, knowing, acting and feeling in "midwife moments" which are then transformed and integrated into feeling confident as a midwife. During this process the new graduates valued the ability to contact the mentors, and they particularly valued the opportunity to meet together regularly as a group of new graduates and midwives in a safe, supportive and rich learning environment.

The mentors were very much in agreement with the new graduates' assessment of the contribution of the meetings and the group mentoring processes. However, their experience was as "one removed" and as responder, rather than as the active partners in the mentoring relationships. This was the major theme that came out of analysing the mentors' interviews, as described in the next section.

Mentors as One Removed

The four mentors were each interviewed three times during the year. This section presents the main themes that emerged from analysing these interviews looking for answers or comments about the challenges and responsibilities of mentoring. The mentors' views on the group mentoring model changed over the course of the year and are presented here in three sections based on their interviews at the beginning, middle and end.

Differing Expectations, but a Responsive Stance Seen as Appropriate

An enthusiasm for mentoring was obvious from the mentor interviews early in the mentoring year, as was the hope that they could pass on their practice wisdom. The

following quotes from each of the four mentors illustrate this enthusiasm and the slightly different views each held of what the mentoring year would contain. One needed a framework for mentoring, as she proposed:

> I feel excited by the idea of mentoring but [I] need a framework around what mentoring is; making myself available, supporting and providing a sounding board, accessing their knowledge but I am also happy to share what I would do in my own practice. (M1, 1st Interview)

Another had a vision of what might happen in regular meetings between the mentors and new graduates:

> My vision would be that initially it would be quite, it would have regular meetings that the meetings might take a particular format in terms of conversation but from the mentors' perspective it would be very much a listening and responding to questions rather than trying to direct. That's what I imagine goes on in the group meetings and then of course there's the one on one discussions that will happen when you're actually on call for the midwives for whatever the period is that you're on call. (M2, 1st Interview)

A focus on the weekly meetings was also reflected in the early thoughts of the third mentor.

> I picture weekly meetings that are reasonably demanding but, but quite fun because everybody's just really in a good space at the moment. I mean very keen and enthusiastic and the meetings that I have had so far people have been quite clear and able to be really honest and really open with each other

> and given, given the personalities I am sure that they will. So I kind of focus
> on those weekly meetings as being the, the main source of energy out and the
> main focus of the mentoring project. (M3, 1st Interview)

The fourth mentor's focus was on the opportunity to work with a group of vibrant midwives:

> They're amazingly vibrant and you just want to be able to have a small part
> of facilitating them, holding onto that. I like the opportunity to be able to
> work with those new midwives, they're all very different personalities but
> they've all got a shared philosophy that's really vibrant isn't it? (M4, 1st
> Interview)

In the first interviews, mentors expressed fears about things that might go wrong during the project, such as internal conflict, death of a baby or mother, medico-legal disputes from giving mentoring advice, or the new graduates being dissatisfied with their mentoring. None of these actually occurred.

The mentors found that their experience of being the passive or responsive partners within the mentoring relationship was an appropriate stance for them. One mentor described in the first interview, how she saw the position being taken by the mentors in this project, "it will be very much a listening and responding to questions rather than trying to direct" (M2, 1st Interview). In the first interviews, all the mentors agreed that this responsive rather than active position was an important principle for a mentoring focus, which they saw as more of a developmental rather than a didactic teaching role. The new graduates were in the active role; they

controlled when the mentoring meetings occurred, and, since they initiated calls to mentors, they determined how often and for what period of time the mentors' expertise and experience would be required.

Concerns about Being too Passive

During the second interviews, however, the mentors appeared somewhat frustrated by their responsive position and they expressed some apprehensions about the mentoring process. These apprehensions were that there were or might be aspects of practice to which the new graduates were blind. The first quote below is about one mentor's concern with the new graduates' lack of time off. The mentor thought that the new graduates seemed to be staying too long at births without seeking cover from the others. Although the mentors had spent time discussing the importance of self-care they seemed unable to effect a change in the new graduates' self-care:

> I would like them to have learnt to look after themselves better. And I don't think they're doing that so that's a shame. And that may be the straw that will break the camel's back. Because even more than mentoring them into normal birth I think we should have focused on mentoring them into focusing on sustainability of practice. And we haven't done that. (M3, 2nd Interview)

This raises a question about the scope that mentors had to intervene and whether they were responsible for the new graduates' practice management. The mentor above was suggesting that mentoring ought to be directed toward having an impact on the new graduates' ability to create sustainable practice structures, "more than mentoring them into [increasing rates of] normal birth."

Another mentor in the second interview commented somewhat similarly about the new graduates' practice management. In particular, she was referring to their lack of time away from practice, but she began by discussing the mentors' conscious decision to encourage and support increasing rates of normal births:

I don't know what the rates [of normal birth] will be like but I think we've helped [to] put the intervention into perspective and talked about some of the reasons why. I think we'd be naive if we were just to say oh well, reduce your intervention rates … because they have to work in this context which is very complex … just to help them unpack the reasons for interventions and to support them in their decisions and to give them some alternatives. I don't know if it will make any difference or not given that nobody has made a difference with the way they've organised their practice. Philosophically they're very normal [birth focused]. (M3, 2nd interview)

The mentors also expressed frustration with some aspects of the meeting process at the time of the second interview, including that the time spent at meetings was not used as well as it might have been. The mentors were all clear that it was in the process of storytelling that much of the learning occurred, both for those who spoke and for those who listened. Therefore in the following quote, the mentor argues for the new graduates to have their practice meeting before the mentoring meeting, where they could discuss beforehand what they would bring to the mentoring group meeting. She thought this would help to raise the level of critique.

There needs to be some way of uplifting of them presenting their practice so that you can actually provide critique. And I don't think we have enough time. We've limited it. And it's not enough time. That's why I'm happy to go through an hour before our meeting to be able to get them to talk about their practice to each other and work out amongst each other what are the issues we like to bring to the table where the mentors are. So that we can explore them, take them apart and see what we can learn out of them. That's what I'd like to do. (M2, 2nd Interview)

Two of the mentors took turns to turn up an hour earlier as observers to support the new graduates to establish a regular meeting habit. The thought was that by supporting them having their own meeting before the mentoring meeting, they might be able to organise themselves better for time off, and use the mentoring meetings more constructively. The mentoring meetings were planned to take one and a half hours, but it was obvious by the middle of the year that more time was needed to avoid a sense of rushing. The hope was that if the new graduates met earlier, the mentor meetings would become sharper.

I don't know that we're giving them enough time because that's where the learning occurs [at the meetings]. You know the most we're getting is one story per meeting and or two very scrambled ones… using the tool with four stories is probably going to take us a good couple of hours isn't it? And that's mentoring and that's the guts of the mentoring because you can sit by somebody in the birth room and they're saying "yep that's right, yep that's right, that's right is there anything else?" But it's the reflecting that you do

> when you tell stories or listen to each other's stories and that resonance you know that whole, "oh I remember when there was one of those" you know – that's when the learning occurs. (M4, 2nd Interview)

The mentor above was identifying how the new graduates' stories resonated with her own experiences, and that a sense of shared meaning often arises; as she says, "that's when the learning occurs." This resonance between the stories of the new graduates and the mentors' memories of similar stories catalysed a depth of understanding about the work of being a midwife. An interesting twist happened for the mentors who reflected on the experience of "not knowing" and "uncertainty" as they responded to the new graduates' calls to come and support them during a birth, and wondered whether this was how obstetricians felt:

> I can even identify with obstetricians which is interesting because the information we are given is not packaged in a way you can easily make sense of it so I get impatient. For me it's about my learning how to ask the right questions as it takes ages to get the actual story out … I want to change the group process so we get crisper stories. (M1, 2nd Interview)

Experiencing a shared view from another health professional's role, such as that of an obstetrician, was reflected in other interviews, for example this time as the on-call mentor called in to support a new graduate during a birth.

> I think I gained a lot of insight into what it must be like to be the obstetrician being called into a room when you have no idea what is going on. That was pretty scary but a useful thing to have learned. (M2, 3rd Interview)

Taking responsibility as a mentor has a number of edges to it; one is giving advice or being reassuring to a new graduate over the phone. One mentor unpacked the level of mentor responsibility entailed with being on-call:

> I got off the phone thinking "I haven't even seen her [the woman]." Normally I would have seen her. If it was my woman, I would have assessed her and seen her and felt safe about it and felt safe about not sending her to the doctor. But because I was further removed … the mentoring thing when you, you're more removed. You don't eyeball these people when you're on the phone …. But I certainly wouldn't say to her "I'm sorry I can't give that advice to you over the phone because I don't know and I hadn't seen her." That would be… medico-legally… when you're mentoring you have to be sensible about risk really. (M3, 2nd interview)

There were times, particularly when on-call, that mentors felt being non-directive was desirable but quite stressful. The on-call role was often less relaxed than the meetings for the mentor who was providing the 24/7 support for the week. They felt "in the dark", in the sense that in their role as a sounding board, the quality of support offered needed to be as accurate and reliable as possible; but often there was a lack of background information, and the responsibility of acting professionally weighed heavily at times.

> I got a call about "the woman with the stretchy cervix that went home." I said "what do you mean"? She said "she's kind of stretchy to five but she's going

home." And I'm thinking "far out". "Oh okay, that sounds fine" and I come

off the phone thinking "Oh my God." (M2, 2nd Interview)

This particular conversation left the mentor concerned about the consequences and

whether she should have said more, but she was aware that the new graduate had

assessed the woman and discharged her already: "well, we made a decision we're

going home and she is 5 cm. Do you think that's okay"? One view would be to take

the stance that, "well if you are worried of course you should say so"; but

mindfulness of the consequences of intervening as a mentor was also important. The

mentor chose instead to ask questions: "how is the condition of the baby, and how

many weeks is she?" because none of that was part of the story. The mentor was

unsettled by what she heard: "every fibre of my being is screaming, 'I can see that

written up in papers: left a woman in active labour at 5 cm and shit happened and the

baby blah blah blah'" (M2, 2nd Interview).

There was more to her concern than the new graduate's decision to discharge

the woman.

I was really worried. And this [poor outcome and the newspaper] is what I

was worried about. I also worry that if you say you're worried at the time you

increase the problem by undermining the new graduates' decision making.

(M2, 2nd Interview)

What actually happened in this instance was that the new graduate "rang back within

the hour and said the woman was going into hospital, so the words didn't even come

out of my mouth" (M2, 2nd Interview).

Sometimes the mentors' frustrations were a product of their past practice experiences. The mentor below is trying to unpack a sense of her uneasiness about the new graduates' lack of time off, only to find that this dove-tailed with a strong memory of her own of lacking practice support and how untenable that had been:

> To ground them, to keep them, you know just to let them feel more solid in their practice, more grounded or something. I don't know what it, what it is.
>
> [Interviewer]… so, can you give me an example of that?
>
> Umm, what was an example of that? I think when we were talking about, umm, needing to get cover, needing to get them organised into cover last time, and we started to do the rounds, you know do the rounds about talking about how it was and why it was important. And I think, I don't know why I spoke to it, but it brought up from my own practice a terrible feeling that I had no cover. You know, I had four midwives' case-loads for about four days with no cover. (M3, 2nd Interview)

The mentors wanted to share their practice wisdom without the new graduates having to share similar poor experiences from lack of supportive practice structures. The mentors all struggled with how to resolve their particular frustrations with mentoring, including how little time was spent on discussing the evidence for practice:

> …evidence comes up in a very small way, because often they are not questions about what is the best way of doing X, Y or Z. And in many cases it's not anything that has evidence attached to it. A lot of it is being

> managerial or organisational kinds of issues that have come up and in terms
>
> of the collegiality. (M2, 2nd Interview)

This quote references the new graduates' strong focus on the hospital environment and culture with which they [new graduates] were trying to come to terms half-way through the year.

Looking Back, the Group Model Worked Well – Especially the Meetings

By the third interview at the end of the mentoring year, many of the mentors' earlier frustrations were resolved, and they expressed a sense of how successful mentoring in this group way was:

> So yeah I think it has been fabulous there are lots of things, lots of times
>
> when I would have liked to have intervened [but didn't]…but as a group I
>
> think it ran well. And it was fascinating to me that the in-depth stuff they are
>
> just not ready for. (M1, 3rd Interview)

Another revealed her own learning while listening in the group to the sharing of practice stories. "I would be quite happy to sit there for a long time listening to them because their stories are so fabulous, and I get so much out of them" (M2, 3rd Interview).

The group mentoring was preferred over one-to-one mentoring, as revealed in the final interview with the mentor who reflected, "Having had this experience, if you have this experience I really believe that people should be mentored by more than one person. So there shouldn't be one on one [mentoring]" (M3, 3rd Interview).

A positive regard for the group mentoring process was also apparent within the organisation in which the new graduates practised, as evidenced by the following mentor:

Oh look it's up, it's up the top, and it's gone really, really well. I think it's been a tremendously successful process. And I think the feedback from both the mentor midwives and the midwives within the organisation where I work has been really, really positive. It's been known about and that's been really important. (M4, 3rd Interview)

The mentors all believed that the structure of the group mentorship and the mentoring meetings was important, and that it enabled the new graduates to take away a useful process into their future career:

And I think that they've gotten to that point with their group stuff which is really good and I think that that's the structure that will support them to keep going in the future because you actually need the structure otherwise it dies away. (M4, 3rd Interview)

The meetings were strongly endorsed and attended, and this was the place where the new graduates were comfortable to reflect. There were either three or four mentors at 21 of the 31 weekly meetings; on only one occasion was there only one mentor present at a meeting. This strong mentor attendance at meetings shows the strength of the commitment made by the four experienced midwives.

The mentors all agreed that the meetings worked well, and that they were "…an easy non-threatening way to do it [mentoring]" (M4, 2nd Interview). After a

few months, it was clear to the mentors that the meetings held the key to providing the new graduates with support for reflecting on their practice: "… it feels like the meeting is the major part of the mentoring because you can sit beside the person in the birth but it is the reflecting which is where the learning occurs" (M1, 2nd Interview). The mentors' opinion of the meetings appeared to mirror those of the new graduates. The mentors enjoyed the meetings, finding them both fun and stimulating, as the following quotes illustrate:

> Doing a quick round [at the meetings] is good so long as we don't get stories in the quick round. But I think the weekly meeting is a key [to successful mentoring], not "the being called out" thing … As soon as we use the tool you could feel they just deepened their reflections. (M1, 3rd Interview)

> I enjoyed the weekly meetings. It was a big time commitment but I always enjoyed them, there were always interesting things that came up, I wished they were longer so that we had time for everyone to tell their stories but clearly you can't sort of occupy all of their working and family time. (M2, 3rd Interview)

> So whether with other mentors it would have been different I don't know. But for us it was, I think it was great and I really enjoyed it. I never felt "oh my God I've got to go to that meeting." (M4, 3rd Interview)

> Oh yes, oh yes, the meetings I was absolutely engaged with and felt I contributed really well and enjoyed them, enjoyed the stories, enjoyed

hearing the mentors' input as well because it was all slightly different. (M3,

3rd Interview)

Summary of the Findings from the Mentor Interviews

All of the mentor interviews, although individually exposing slightly different

expectations and foci of interest, showed a similar pattern of initial excitement and

enthusiasm followed, six months later, by some reservations, and then in the third

interview expressing a sense of a job well done. The mentors all showed some

reservation in taking the responsive rather than active position, because it gave less

scope to intervene in the new graduates' choices. However, the mentors also saw

that their taking a responsive approach was important for their learning about

inspiring insightful reflections through careful questioning, rather than by resorting

to advice-giving.

<div align="center">

Summary

</div>

Overall this chapter has shown from three different perspectives how, with

the support of a small group of mentors and peers, four new graduates gained

confidence over the course of their first year in practice. They began with

apprehensions but were ready, with support of experienced mentors, to take on the

challenges as responsible practitioners. Over the first half of the year, they called on

the help they needed in ways that suited them individually, they shared their

experience with the group, and they gradually became more confident in their own

competence. Despite some frustrations at times, their mentors supported them and

waited to respond to their needs. By the second half of the year, the new graduates were asking for less and less assistance, but continued to enjoy and learn from the opportunity to discuss their experiences with colleagues as well as mentors – and to learn from these experiences.

When new graduates and 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. The group is also the aspect of the model which is novel, when compared with the more usual one-to-one mentoring. Because of the importance given to these meetings, the next chapter is devoted to presenting a detailed thematic analysis of meetings during the course of the year, in order to explore what took place: what matters the new graduates chose to discuss, and how the mentors responded.

V.   FINDINGS 2: GROUP MEETINGS – ISSUES AND RESPONSES

As described in the previous chapter, both new graduates and mentors identified the meetings as the most important part of the group mentoring model. This chapter presents the findings from analysis of recordings of those meetings. Looking in some detail at what happened in the meetings helps in understanding how the group mentoring model worked. It also throws light on the sorts of issues for which new graduates choose to seek mentor support, and how mentors respond.

Two phases of analysis were undertaken: the first was an in-depth analysis, on two levels, of the concerns and issues that new graduates brought to the meetings, and the second explored how mentors responded during the meetings.

In the first phase, two levels of analysis were undertaken to identify different aspects of the new graduates' concerns. The first of these levels of analysis looked at the scope of the areas of heightened concern for new graduates, and in particular "where", in practice, these concerns were placed. It elicited the following five categories:

- administrative issues

- the working environment

- group culture

- professional culture

- clinical issues.

The second level of analysis focused on "what" sorts of issues a new graduates chose to bring to the meeting, and "why" – what prompted them to do so? This second level of analysis involved an extensive and iterative coding process, initially identifying ten detailed but overlapping sub-themes, which were subsequently grouped into three major themes:

- self-reflection

- issues to do with others

- technical issues.

The second phase of the analysis concerned the mentor responses to the new graduates, and focused on the process of the mentors' engagement within the meetings.

Phase One: New Graduates' Concerns

The mentoring meetings were grounded in the notion that the mentors were there to listen to the concerns brought by the new graduates, and that the new graduates were the active partners in the relationship. Therefore as I read and listened to what was said at the meetings, I was drawn to the range of concerns initiated by new graduates, because that indicated what issues were on their minds and needed to be discussed. This analysis offers an insight into their experiences as newly responsible practitioners, as well as identifying what it is about an issue that means they are more likely to want to discuss it with their mentors and colleagues.

Level 1: The Scope of Areas of Heightened Concern for New Graduates

A self-employed midwife's work is wider than the immediacy of contact between the midwife and the women who have chosen her as LMC. For example, there are aspects to do with administration, managing a business, and understanding the law and regulations as they are applied to one's work, with clients both in the community and in hospital. Within the hospital, there are policies and protocols. Within both community and hospital practice there are different cultural norms, in addition to discipline-specific knowledge of the human sciences and clinical skills in relation to childbirth. My interest initially was in determining which areas, across the whole scope of practice, were the ones that the new graduates mostly chose to discuss in the meetings.

The new graduates' concerns were "located" in the five categories previously listed: administrative issues, the working environment, group culture, professional culture and clinical issues. These categories applied throughout the sample of meetings over the year, with more or less frequency. In the following sections each category is described and discussed in turn, along with illustrative quotes.

Administrative issues

Administrative issues were a varied and loose grouping of generally administrative matters. The areas covered included, for example, questioning the need to document phone calls, problems with hospital access agreements, creating business cards, how to obtain letterhead stationery, collating email addresses, questions about who pays general practitioners when women visit them antenatally, Midwifery and Maternity

Provider Organisation, notes and where to find NZCOM feedback forms to give to women when the midwife finished being their LMC. Such administrative issues were mostly dealt with quickly and did not lead to much discussion. Three examples of this sort of issue are: "Where do we get pregnancy tests? (NG 2,1st Meeting)"; "I need to ask you about access agreements" (NG1, 1st Meeting); "Where do you get lancets [for taking heel prick blood samples] from?" (NG4, 8th meeting).

Such simple information gathering questions were evident early in the mentoring year; but after the first eight meetings, these were replaced by stories and discussions about the issues which arose as a result. The change from simple information gathering to practice discussions was swift. For example, in the first meeting, there were 30 such simple information gathering questions, but by the eighth meeting there was only one. This change occurred whilst the new graduates were setting up their business, purchasing equipment, using their registration to gain access to hospital facilities, and learning about the appropriate paperwork for claiming maternity fees. Their introduction as midwives to their new working environment was an enormous transition as they began seeing clients and attending births.

Working environment

The second area concerned the working environment, and included exchanges relating to the new graduates' work both in the worlds of the community and the hospital. These concerns included their relationships with others, as well as their understanding of how the systems worked in both environments. There was evidence

of questioning the place of the midwife within the system, how that accorded with the regulations, and about the bases for on-going collegial relationships.

For example, one new graduate said, "I went in with the bloods and said – he said 'we need to induce', I said 'why' and we talked about it. [He] rang the consultant and she said the same" (NG4, 14th meeting). In the meeting a conversation then developed with the mentors and new graduates around the management of situations where there is little place for a negotiated conversation between the medical staff, the woman and her LMC midwife. A similar story had previously been discussed in the same meeting, so NG4 suggested that the group lift the conversation out of the specifics of this case and discuss the maternity regulations around consulting, and what was possible in the way of gaining a second obstetrical opinion. "Shall I start discussing issues around consulting and about second opinions; is it their opinion or is it a three-way conversation like [as it is specified in] section 88 (2007b)" (NG4, 14th meeting). Here the new graduate was trying to understand the power or lack of it in her role as LMC to have a three-way discussion. The notion of a three-way discussion was written into the maternity regulations but what she experienced was a sense of powerlessness in relation to her ability to have a discussion about whether an induction needed to be done urgently.

In another situation where a client birthed a baby with an undiagnosed breech presentation in hospital, the obstetrician responded quickly and managed the vaginal breech birth. Afterwards he explained to the new graduate that had this birth occurred at home, the baby would have died. The new graduate found that his telling her this was unnecessary and rather frightening, but she acknowledged his support

and responsiveness to her particular clinical situation. "He [an obstetrician] ran from his woman [patient] to ours; I felt supported by him" (NG3, 22nd meeting).

The new graduates were experiencing contradictions in coming to terms with the responsibility and limits to their role. On the one hand, an obstetrician can take over the woman without regard to the thoughts and opinions of the woman or her LMC. At the same time, a swift obstetrical response when it was needed in a clinical situation left a new graduate feeling very grateful. This experience was rather sullied, however, by the obstetrician's expressing the opinion that the baby would have died if it had been born at home.

The new graduates were confronting a confusing conundrum of finding the system supportive when needed, but also challenging and somewhat demeaning of them at times. There was confusion around knowing what were treated as "rules" and what instead guidelines to best practice. For example, one new graduate asked, "Do you have to be induced if you have had a previous LUSCS?" (NG4, 26th Meeting). The mentor responded that this was not the case, and in fact it was "against [the hospital] policy" (M4, 26th meeting).

In the next scenario, a client was insisting she be induced at 40 weeks gestation, and the new graduate LMC was feeling the pressure from her to organise an induction. The mentor responded to the new graduate's distress:

Is it not ok to listen to the woman and say ok and induce her at 40+7? [Chatting over one another] You have talked about the normal scenario … In the end our relationship is with the woman and our partnership is about

working out what each of us brings to that and if that's what they want – it's

her birth. (M4, 25th Meeting)

The graduates were incensed that they should have to compromise their beliefs and

ignore the research about encouraging a spontaneous onset of labour to achieve a

normal birth.

We have decided as practitioners to practice in a certain way and we have the

right to do that and we tell people how we practice, why do we have to

compromise our professionalism. We will finish up inducing every second

woman. (NG3, 25th meeting)

The mentor challenged the idea that agreeing to an induction was a compromise, and

talked instead of the partnership between midwives and women:

I don't think it is a compromise, people understand what your values are and

your ways of working and you talk to them so it's the skill level that you use

around women who are tired and fed up at 39 weeks and you are not by

compromising on the way you see the model working but within that [social]

model there needs to be fluidity. (M4, 25th meeting)

The new graduates were finding their place in the working environment, both within

the hospital and with their clients in the community. This was not always an easy

process, and having the opportunity to discuss the experiences with their mentors

was all a part of the group process.

Mentoring group culture

This theme covered exchanges about how the mentoring group itself worked, for example, which mentor was on call and who was facilitating the meeting, and the general chat, laughter and sometimes tears which accompanied each meeting. The group mentoring process unfolded naturally, enabling the new graduates to have as much decision making and facilitative power as the mentors. The new graduates and mentors took turns to facilitate meetings and direct the process, for example: "We are talking about consultation? Feel free to pass if you have nothing to say" (NG 1, 14th meeting).

Sharing facilitation between the mentors and the new graduates enabled the new graduates to assume power within the group process from the beginning of the group mentoring meetings. This sat comfortably with the mentors, who wanted the new graduates to move away from a student model of being taught to one of claiming their learning opportunities. The new graduates showed that they felt comfortable to critique whether the mentoring was functioning well or not, and therefore how effectively supported they were by the arrangements in place. The following quote illustrates the new graduates raising an issue reasonably early on in the year about improving access to mentor support: "Three in labour and needing support doesn't work; because we have no process about a second [mentor] on call" (NG 4, 8th meeting).

This example was referring to difficulties encountered when three new graduates were each looking after labouring women and wanted to ask for mentor

support, but only one mentor was on call. So the new graduates were emancipated enough and not intimidated by their experienced mentors. This somewhat confirms the interview findings that they felt strong enough to raise the issue and ask for better back-up from the mentors. The new graduates also talked about their own back-up arrangements for days off during the mentoring meeting, when conversations arose about which women were due to give birth. These were important sources of information for the mentors, as they otherwise had no idea about the likelihood of being called or not. "Clarifying weekends off and on, I am going to be on the next two weekends" (NG3, 25th meeting).

The mentors had an on-call roster which was organised many weeks ahead, but the new graduates took quite a long time to organise a system of days off. In the second half of the year, this level of organisation in their group was much more evident. The mentors consciously tried not to interfere in the new graduates' practice unless asked to do so. There was a balancing act at times between the mentors wanting to know what had happened with a scenario they were rung about during their week on-call, and appreciating that this was not their core business. On one such occasion, a new graduate was asked about what they had learned from an experience the week before. She said, "I didn't really want to go over this because I have something else I want to discuss" (NG4, 26th meeting). The principle was for mentors not to ask about "cases", but to wait for the new graduates to offer their experiences; however occasionally questions were asked, as happened in the situation above. The new graduate told the story she was asked about, and also the one she was more interested to tell, but she did express her feelings about being

asked to talk about the case. That discussion was from the 26th meeting, and the new graduate sounded as if she was really in charge of the interaction here, which showed her taking up the active role within the mentoring partnership.

Professional culture

Professional culture entailed discussions about what it meant to be a midwife. This included, for example, being a professional in general, or fulfilling the regulatory bodies' requirements, such as the Midwifery Council's requirements for an Annual Practising Certificate, or attending the NZCOM's local meetings, or how the national standards for practice or code of practice were played out in practice. The whole of the first quote below was from one new graduate:

> For me it's the whole thing about it's my first year of setting myself up and in setting myself up I want safety, really good outcomes for my women, safe outcomes, I get amazed even as a student by what they [women] expect of you. And you want to do it. It is one of those professions that come from the heart but not always that appreciation from the heart from the other side. I had a deep appreciation of my midwife but I get amazed when other people don't have that even though you have set the record straight that this is what I do and these are my boundaries. When you communicate with them that clearly and fully and when you do that much and you are still fragile. Midwifery as a profession is very fragile and even though you fully communicate with women they forget and in the current climate you may be in the news tomorrow because of a horrible outcome. The responsibility of

the midwifery profession is that we make sure that everything is done safely and realise it may not be perceived as such. You don't get more intimate as a professional than as a midwife – if I don't get anything back from clients it is really hard to feel safe with these people – [I] want to feel professionally safe with them. I am starting to feel a bit like that with a few clients. (NG3, 9th meeting)

This long quote expressed the concerns shared by the new graduates about the women they were booking and working alongside, using a model of partnership as their guide to practice. In my view, this showed a differently nuanced "talk" to that of my generation of midwives, reflective of the cultural and professional changes which have occurred in the last two decades. The newspapers have sensationalised critical incidents and baby deaths, particularly those who have had a midwife LMC (and more recently a new graduate LMC); this has promoted fear in midwives, as is evident in the quote. I was struck by the distance felt by this midwife toward some of her clients, compared to twenty years ago where women and midwives shared the common goal of humanising childbirth. At that time we cared for "women" rather than "clients"; since then, the language, the regulations and the culture have all altered. This is not reflective of all partnerships. The quote below exposes a despondent view about birth planning, and some shock about the connection this new graduate has with her clients. My sense on reading this was that she was surprised how much she thought about her clients, and that she had little faith in planning births with women.

> I haven't seen care plans go the right way [this was a response to a discussion about a birth which did not turn out as planned]. Lots of women don't know how much you think about them. (NG1, 9th meeting)

Some comments were practical ones about the business of preparing a portfolio:

> My week was about the portfolio. I rang the Midwifery Council, I told her it wasn't clear about putting down times [hours of work] but times are not important for independent midwife, did lots of reflecting and writing and wrote about scope of practice I did different scenarios; I talked about a couple of critical incidents, personal professional plans, then stories of out in practice, reflections on each of the workshops. (NG4, 29th meeting)

Professional issues were frequently mentioned and discussed, as the new graduates began growing their professional selves and adjusting to this new culture. The range of professional issues is vast and requires the midwife to develop a professional persona. The regulations are more hard edged than they were twenty years ago, so that the public is protected by midwives fulfilling more stringent levels of accountability. At the same time, midwives are working with a social model of childbirth which is based on building relationships of trust. When midwives and women connect in this way, the expertise of both is harnessed to engage in the woman giving birth physiologically, or being referred, in an appropriate and timely manner, for obstetrical or other medical oversight. The clinical aspects of providing care to women were a frequent though not overwhelming aspect of the new graduates' concerns.

Clinical issues

Clinical issues were, as the dictionary suggests, about "the observation and treatment of patients directly" (Collins, 1990, p. 179). Although the use of "patients" in this definition is more medical than in midwifery, it is a fair description of how I have used the term "clinical". The following quotes are examples of the concerns about clinical issues brought to the meeting by new graduates.

> She had made her own antibodies and she doesn't need anti-D. (NG4, 9th meeting)

> When I consulted I asked about ECV [external cephalic version] and vaginal birth and told risks too high. If I'd known before she went into labour and she had decided to have a vaginal birth [I would have organised an ECV]. (NG2, 14th meeting

This was a case where the woman had planned a home birth, but because her clinical observations were worrying, in particular the fetal heart, she was transferred prior to a vaginal examination being performed; but one was done in hospital, and the midwife discovered the baby was presenting by the breech. The midwife consulted with the obstetrical team, but as the woman was in labour it was too late for using techniques for turning the baby. As a result, the woman had a caesarean section and the new graduate was feeling responsible for not picking up that the baby was breech; she had tried various ideas during the consultation to change the impending surgical scenario.

The clinical issues were focused predominantly on labour, but not always; as the quote below shows, the ability to support breastfeeding women requires much skill, and supporting the new graduates happens "in the field" as well as during reflections:

> I don't think I am telling them the right things; I thought we were supposed to empty one breast, and she [lactation consultant] said just wait until they fall asleep and then wake them up and put them on the other side. I am just having a few problems. One [baby] isn't putting on weight, one hasn't put on weight at four weeks and another woman is a cot case and she started formula yesterday and then she rang to say the baby was throwing up. I need to do the breastfeeding thing [workshop] but up to now it has been good. (NG1, 26th meeting)

Lactation consultants are more numerous now, and they spend time with the woman supporting her, but also educating midwives when they strike situations they haven't met before.

Considering the level 1 categories

The five categories above represent what was discussed at meetings. They were of interest to me because they begin to answer the questions about where, across their whole scope of practice, the new graduates' concerns lay.

In the meetings, the new graduates were free to be the active enquirers, without being judged or assessed. If they raised an issue in the meetings, then they were heard and their concerns were discussed. Thus the questions or issues they

raised were ones which were of interest to them. The five categories were derived from analysis of the data, rather than being driven by any theory.

The new graduates' concerns about the role of the midwife suggested broader questions which captured their concerns, such as: "how much of my role is negotiable?", and "do I have to follow these rules and if so, which ones and on what basis?" These questions are clinical and professional questions about what is expected of a midwife, but are also about becoming socialised into their working world. I became interested to know not only what parts of their practice generated questions, but also whether I could understand what sorts of issues led to them wanting to discuss issues – or perhaps why one issue was brought to the meeting and another was not. Thinking about these questions led to the second level of analysis.

Level 2: Why New Graduates Choose to Discuss Particular Issues

The first level of thematic analysis looked at the items that new graduates chose to talk about in the group meetings, and identified the areas within the scope of practice in which items lay. I was interested to find out more about what sort of situations prompted new graduates to raise an issue for discussion. For example, was it because of a need for information about a technical matter, or because of some concern about their own feelings, or perhaps because of relationships with their clients or with other professionals?

To explore this question I re-read the previous six meeting transcripts and added a further five, so as to also have some new material to work with and to ensure that my analysis was likely to hold for all meetings across the year. I had

established the five categories using mostly isolated quotes from the new graduates, and focusing on the scope and the role of a midwife. However, I became aware that often the reason for the presentation did not become obvious immediately, but was clearer in the course of the ensuing discussion. So for the second level of analysis, I looked at threads of discussion between the new graduates and mentors. Each thread began with a new graduate mentioning an issue or question that they wanted to discuss; then I examined the thread of conversation that followed, with contributions from new graduates and mentors. A fairly simple example of a thread is given in Table 6 below.

Table 6: Example of Thread of Conversation (1st meeting)

Speaker	Speech
NG1	We want to ask a really dumb question.
M1	Good we like dumb questions.
NG1	When we are writing to hospital referring people, who do we refer the woman to? Like this woman has fibroids – who do you refer them to? We were told to refer but not who to.
M2	Do you mean who do I ring or where do I send a referral?
NG2	Where do we refer them to? Is it a particular doctor?
M1	You could ring the hospital and talk to a particular doctor. You could ring the hospital outpatients and ask what they prefer; they need to grade them anyway.
M2	When you write a referral begin the letter with "Dear Doctor, thank you for seeing ...and then give the reason for the referral and the past and present history".
M1	There may be a more personal way of doing it by ringing and talking to the doctor.
M2	It's different if an acute thing.
M3	Is the woman term and do you want her seen within 48 hours but not urgently?
NG2	It is a 3 on the referral guidelines. I will ring outpatients.
M1	Good to get a pad to write it on and fax it so you keep a copy.
NG1	We were taught the format for writing the referrals but I just didn't know about where or who to send it to so I'll ring outpatients.

NG= new graduate, M = mentor, plus 1, 2, 3 to represent individuals

Across 10 meetings, I identified 95 such threads of conversation and started to code them according to their content. Initially this resulted in my identifying ten sub-themes but I found that these sub-themes were not especially clear or illuminating, since it was often possible to code items to several of the sub-themes and it was difficult to decide where they were best fitted. Through a further reading

of the material and an iterative coding process, I gathered the ten sub-themes together into the three broad themes as listed below. (After the names of each of the broad themes, I have included in parentheses the names of the relevant sub-themes that were used to make up that broad theme.)

- Self-reflection (reflecting on inexperience, reviewing and appraising one's own practice, sharing achievements and when things went wrong).

- Issues to do with others (client emotions, new graduate peer support, observing how others practice, negotiating the pecking order).

- Technical issues (administrative detail, clinical know-how, complexity of clinical and social issues in the community).

Of the 95 threads of conversation, 25 were coded as self-reflection, 31 as issues to do with others, and 39 as technical issues. In the following sections I discuss each of the themes and give examples taken from across the ten sub-themes.

Self-reflection

Self-reflection led to a number of different sorts of issues being brought to the meeting – often as a result of concerns in relation to inexperience, or where the new graduate was reflecting on something that had happened and was reviewing or assessing their performance.

Early on in the year, the new graduates often discussed the effect on them of their inexperience as they were becoming LMCs. "I was trying to be confident on the phone. I feel like a fraud – we should ring someone else – you need a real

midwife" (NG1, 1st Meeting**).** The new graduates gained confidence throughout the year, but each new experience had to be integrated into their understanding, so that the learning became part of their midwife repertoire. "I hadn't seen people under a GA [general anaesthetic] and have never been under such circumstances" (NG2, 20th meeting). Their level of comfort in this new work world was an insecure one of knowing some things, but being always aware that they would meet yet another new experience. They felt they needed an ability to appreciate each new experience as useful learning, but acknowledged that this was not easy:

> It's really hard – lose confidence constantly – feel as if you – constantly feel as though you have to pick yourself up (do you?) and you do – then you do learn. The only way you really learn something is to experience it. (NG4, 20th meeting)

Sometimes the issues came up from new graduates reflecting on their own performance. The process of practising midwifery as a new graduate entailed constant self-critique and practice appraisal, and this often led to discussions about how the new graduate was feeling about an issue. For example, one new graduate realised that recently she had had a pattern in the labours she had managed: "Maybe looking back I had a wee run of those experiences and where I put up synto [syntocinon a drug to induce or augment labour] for a long time" (NG4, 20th meeting). Another reflected about her feelings after reviewing her practice outcomes: "It's my run of caesars and home birth transfers. When you get that whole run of things outside normal then I feel downhearted" (NG2, 24th Meeting). She was feeling downhearted about "a whole run" of women transferring from home births

and having caesareans. In fact, in this case there was no need for the midwife to think that she was in any way "responsible" for these interventions in normal birth, but she realised that her sense of buoyancy was affected, and that this sense was based on most of her clients having normal births.

Sometimes self-reflection involved a need to share either when things went wrong, or when the new graduate felt a particular sense of success. For example, a new graduate thought she had been criticised unfairly, and managed to account for the misunderstanding with the staff member concerned. "I feel sad about it [sounds tearful] – sorry about this. [Following a row with a staff member] I went back up and said 'could we chat?' I explained about the woman's memory. [hospital staff member] apologised" (NG1, 9th meeting).

Learning to be assertive was a constant challenge as new graduates confronted criticism or a sense of being discounted. The next example was about a registrar wanting to induce a woman late in the afternoon when it was not urgent, and both the midwife and the woman had not slept. "This time I need to do what is good for us. I actually stood up for myself. I felt last time I got over ridden and I thought 'no, I have to do what is good for us'" (NG1, 14th meeting). The new graduate had met the situation before and knew now that the hospital protocol supported her resistance to a rushed induction, so she had a reasoned argument for not being "over-ridden" this time.

At other times the new graduates reported feeling overwhelmed, "I have had a bad week; I was in tears in Caesar theatre. It had turned into a horror. I left after

that because I couldn't do it any more" (NG2, 20th meeting). She left the woman in the capable hands of another midwife, knowing she had reached the end of her tether through tiredness, and was shocked at the turn of events. Another new graduate reported a success very openly:

> Friday had a birth and I felt like a real midwife. I feel I was on the mark! I practised how I wanted to practise – three and a half months what a good transition! Where I am at now I feel I was right on the mark. (NG4, 13th meeting)

These examples of self-reflection show how midwives were able to look at their own thoughts and feelings, and how such introspection often resulted in issues or questions that they chose to discuss in the group.

Issues to do with others

There was often a tension between how the new graduates perceived themselves as autonomous practitioners, and how others responded to them. Many issues arose from this tension or other aspects of their relationship with others – including other professionals and peers, as well as their clients and their families. Many of these issues to do with others were related to the new graduate's autonomy and agency in relation to others, such as whether they were able to have a voice, show confidence or be silenced, their concern for women, babies and the family, finding the boundaries of professional practice, establishing networks of peers, mentors, staff midwives, co-ordinators and other LMCs.

Sometimes new graduates experienced clients who were expressing various emotional issues. The new graduates were managing their own emotions through their transition to independent practice and found any extremes of emotions of others unexpectedly upsetting. "She thought she was going to die; she was so distressed I felt I had to stay; I took the baby out to dad. They were overwhelmed and happy" (NG2, 20th meeting). The new graduates were learning about the emotional work of a midwife, whether this was during labour, antenatally or over the four to six weeks of funded postnatal visits. Whilst one mother remained in hospital, her family cared for the baby at home. "I have been doing the follow up care; baby at home, lots of paranoia, her mother is looking after baby with a mask on, they are very scared" (NG3, 29th meeting).

Sometimes events happen about which the family is especially happy. In another case, a woman had a vaginal birth where usually she would have had a caesarean section for a breech presentation, because the breech was undiagnosed and it was too late for a caesarean.

> I debriefed with them this morning; the husband hugged me and said he was so glad. He was grateful to her and he rang his family … and he feels so lucky to have me and they are all feeling fantastic. (NG3, 22nd meeting)

The new graduates were very affected by their clients' feelings and although they often shared their observations with the group, they did not appear to need to be reassured; just telling the stories of their clients' emotions was important to them.

"She said I am so glad I didn't have a caesarean section and the husband said he was so pleased she wasn't cut" (NG3, 22nd meeting).

As well as issues to do with clients and their families, issues about peers and other professionals were commonly brought for discussion in the group. The new graduates often mentioned how being able to talk to the other new graduates was a wonderful source of support and a boost to their self-confidence. They easily shared their worries and concerns and found an enormous source of support from their peers. "We have talked about client visits – we chat to one another and ask one another what the other one thought. It's been good" (NG1, 1st Meeting). The new graduate peers were also able to provide cover and take over the work when a colleague was tired. "I went for a rest and [one of the new graduates] took over" (NG3, 29th meeting). Sometimes, however, it was only when the new graduate began to reflect on her week that her need for more support became obvious both to her and to others: "Next time hopefully we will be more supportive and you don't have to get to that point" (NG3, 20th Meeting).

The experience of hearing about one another's experiences after the event was important for the peer group even if they had been present at the event. The quality of the reflection after such events changed the depth and quality of the learning. Even more frequently, new graduates talked about how experienced professionals practised – not always in a positive light. For example, after a birth a new graduate was not sure about whether a small tear around the urethra was something she should stitch or not, and she asked for help from the hospital midwife.

As the experienced midwife came in, the woman had a short rapid loss of blood, and the midwife's response was to take over.

> So I said can you come and check this out to get a second opinion. As she came in the woman had a bit of a bleed and it was flowing. Fundus not well contracted so she started rubbing up the fundus and expressed a 100 mls clot, then she was ok. "Jasmine" [staff midwife] put up a line, got misoprostol put in and the woman went to recovery. She was really dramatic and the woman was like "wow, what a drama." I had no idea what to do with this [staff behaviour]. (NG4, 25th meeting)

The not-so-new graduate at this point went on to ask how one manages, not the clinical scenario, but the overly dramatic response by a more experienced and senior midwife to a blood loss which the new graduate knew was within normal range for postpartum. At the meeting she was encouraged to accept this event in the context of her inexperience and how, in asking for a second opinion, there needs to be clarity about what help you want.

In another scenario, a new graduate rang for obstetrical support in a labour when the fetal heart rate was dropping significantly; but when the obstetrician came he initially ignored the fetal heart rate, examined the woman internally and berated the new graduate about her assessment of cervical dilatation. "Anyway he didn't talk to the woman or me and then I was shocked [his response to the woman and herself] because [all] he said 'I told you to get an epidural'" (NG3, 29th meeting). She was very stunned by his lack of concern about the fetal heart, given that he was the on-

call consultant, and therefore it was his responsibility to respond to the specifics of the call for consultation. She was not cowered by his attitude to her and responded assertively: "I asked you to come and check on my [woman's] baby'" (NG3, 29th meeting). A capacity for assertiveness such as this is unusual within hospital systems in general, and not many new graduates have this level of confidence in expressing their frustrations so openly when dealing with consultants.

Often new graduates brought issues to the group which were about how they saw themselves as at the bottom of the "pecking order" within the hospital system and how they negotiated within it. In general they were shocked by how much responsibility they were taking as LMCs, and yet how little influence they had once they asked for an obstetrical consultation. "We had no control over making that choice. They behaved in a way which showed we are not going into that discussion about whether she thought she could do it; there was no negotiation; it wasn't a choice" (NG2, 14th meeting).

The regulations which midwives are contracted to government to fulfil (Ministry of Health, 2007c) call for "three-way" conversations between the woman, her LMC and the specialist with whom the LMC has consulted (usually an obstetrician). The new graduates were very aware of these regulations, but were less experienced in the workplace culture, and that culture was a shock to them all:

My scenario was I went in with the bloods and said "this is the history". He [obstetric registrar] said "we need to induce right now; we'll do it tonight." There was no sort of dialogue. I said "why?" and we talked about it. Then I

said "do you want to talk with the consultant?" He rang consultant and she said the same. No kind of dialogue. Like clicks fingers [not actually but expression used to demote no opportunity or place for discussion]. (NG4, 14th meeting)

The lack of negotiation and discussion, especially when the situation was not urgent, surprised and angered the new graduates, but they were unsure how to manage these experiences. "I wish I had been strong and next time I feel it if it is the same circumstances I will just stand my ground. Can I do that? They weren't listening to me" (NG2, 20th meeting). The new graduates appeared affronted by being treated this way, but persisted in the behaviour they believed was appropriate, and at times this approach worked. "Got Reg [Registrar] to come in and see if we can negotiate this" (NG2, 20th meeting).

The experiences of finding themselves at the bottom of the pecking order created a good deal of reflection by the new graduates. Whilst the "issues to do with others", were varied they were often about how individuals behaved and, as in many of the examples above, were actually about an unsupportive culture. The new graduates' autonomy and capacity to resist the worst of this unsupportive culture and to promote good professional practices was a matter that was commonly brought up and discussed at the group mentoring meetings.

Technical Issues

The technical knowledge category covers a spectrum of both the professional and the clinical knowledge areas which support safe practices, such as the legislation

pertinent to midwifery, government regulations, hospital protocols and guidelines, clinical descriptions and understandings, systems knowledge, such as how hospitals work, secondary services, hierarchies and undemocratic processes, and ethical knowledge, such as the concept of informed consent.

The new graduates were well educated and understood what was necessary in order to perform the clinical functions of a midwife; however, there were many fine details which they had to learn whilst they were on the job. One of these was how the system works between the various primary providers. In the following example, the new graduate needed to know how the funding system works when a woman chooses to go and see her general practitioner (GP) instead of the midwife, despite the midwife having arranged to visit her client in her home that same day. Maternity care is free for women in New Zealand and the LMC is contracted to provide all the publically funded care, so an issue arose for this new graduate:

> Something else I wanted to ask you. A woman rang me and said "I am really sore". I organised to go and see her in an hour and a half and when I arrived she had left home and visited her GP. Now could I be charged for that – how does the payment work? (NG2, 1st Meeting)

In the first few meetings in particular, many questions were asked at this level of detail and the new graduates became aware of how much of such detail was lacking, despite their preparation for practice. This lack of awareness about the systems included what equipment was needed for practice, and where to find the necessary supplies. "This is our list of all the people we have contacted [about obtaining

midwifery supplies] but would be good if new grads have a list when they start practice" (NG1, 1st Meeting). The new graduates wanted to pave the way by sharing their knowledge of the lists and sources of supplies needed with those who followed them, so that they could be prepared ahead of time. The new graduates had all studied pharmacology, but at this point had not written a prescription. "One of my women who I booked through another midwife – got bloods back, ferritin low, still dizzy, writing first prescription. [I am] not sure about supply like 3 months" (NG2, 1st Meeting). They needed at this point to make clinical decisions about how long the prescription should be made out for – a decision which was not rule-bound. This example reflects their world of uncertainty and complexity at the time of beginning in practice.

Sometimes issues were brought up about clinical concerns which led to a discussion of clinical matters. A baby was admitted to the neonatal unit because the mother had a positive Group B Streptococcal result early in pregnancy; but when the new graduate repeated the screening test at 36 weeks gestation, it was a negative result. "Baby now in NNU – thought baby had Group B strep. I took swabs at 36 weeks came back negative. I said 'ok, I think if it doesn't show at 36 weeks then ok'" (NG1, 9th meeting). This response by the new graduate showed she was not aware of the protocol which states that any positive Group B Streptococcus result should have the baby treated as being "at risk". The hospital staff were very annoyed with her advice to the woman, and this left the new graduate very shaky when she arrived at the group meeting – so this issue could also be coded under issues to do with others and self-reflection. These themes are often interconnected, and it was

typical for clinical issues to entail interacting with health professional and gaining insights into those people's emotions as well as their own.

Another example shows a new graduate being skilled at identifying and managing a baby who needs assistance to breathe at birth, as well as knowing how to manage a woman with a low haemoglobin measurement. "Baby didn't spontaneously breathe so needed bagging, started breathing at two minutes, she responded well and quickly and she latched like a dream, she [the mother] is home now, her haemoglobin is 76 but she declined a blood transfusion" (NG2, 14th meeting).

There were times when the new graduates sought help from the hospital staff. The next extract shows a new graduate explaining how she seeks guidance from the hospital midwives when she needs to, indicating respectful collaborative practice relationships.

Then I checked [the woman's perineum] and there was a tear around her urethra so I went out and [the delivery suite co-ordinator] was there so I said "can you come and check this out to get a second opinion." (NG4, 25th meeting)

The next quote, taken from a group mentoring meeting late in the year, shows a new graduate still capable of sharing her concern and asking for information after another new experience. "In terms of post-dates stuff is it different with a VBAC [vaginal birth after a prior caesarean]? I am just concerned with managing something I haven't dealt with much before. She's 39 weeks" (NG 1, 27th meeting). The confidence scales revealed that the new graduates were quite confident in their

practice at this stage, so it is important to see that in this case her confidence is appropriately exercised and she is acknowledging a lack of knowledge in a particular area.

The next quote also taken from a later meeting, illustrates a capacity to give context to a question:

> How long is it ok for the head to be on view? I had this birth where all was ok, the baby was tachy [tachycardia or raised heart rate] for a while, put the CTG on and then variable decels [decelerations of the fetal heart rate] and recovering well; ARM [artificial rupture of membranes], straw [coloured liquor], old mec [meconium], and the heart recovered, she was 7-8 [cms dilated]. We moved to theatre and I was ok with that, got to fully [dilated], didn't want to push. I kept showing them the [CTG] trace and getting it signed and all ok. I told reg [registrar] and [reg agreed] we should allow her to do it, so allowed her to breathe the baby down. I let her do that and I had a peep and baby's head was there, the baby came out with Apgar scores of 4, 6, and 8. (NG 1, 27th meeting)

Here the new graduate is confident and is asking for more guidance and information after reflecting on a case and questioning her clinical decision-making.

Considering Level 2 Categories of Analysis

In summary, this second level of analysis shows the issues that new graduates were likely to bring to the group for discussion. These sometimes involved a need for information arising from technical issues, but commonly were matters that had

caused them to reflect and question their own performance, or the way that they interacted with their clients or other professionals. As demonstrated in the examples, these were often situations that had raised difficult questions or various emotions in the new graduates, and they valued the chance to hear the opinions of their peers and mentors.

This ends the first phase of the analysis which has focused on the issues that new graduates chose to bring to the meetings. The next section looks at the mentors' responses to these concerns.

Phase Two: Mentor Responses in the Meetings

The first phase of the analysis looked at the content of what the new graduates brought to the meetings; this second phase looks at the process of discussion in the meetings. Initially the units of analysis were again the 95 threads of conversation identified within the eleven meetings spread throughout the year. As with the first phase, the process of analysis was an iterative one, involving several readings of the threads. At each reading, I coded the transcripts for different types of responses that might help explain the process and throw light on the different mentoring approaches. As in the first phase, I first arrived at a number of smaller themes and subsequently grouped these together into broader categories.

Types of Mentor Responses at the Micro Level

I started to analyse the transcripts of the threads to identify and categorise the types of immediate mentor responses whenever a new graduate initiated a new topic (an

"offering"). On the first reading, I identified a range of both positive and negative

responses.

Table 7: Mentor responses to new graduate offerings: 1st reading

Type of response	Example of what mentor said
Positive responses:	
Directing the new graduate "to do something".	You could give her the refuge number and slip it to her.(M3, 25th meeting)
	Go and look at policy, if woman and baby ever had GBS [Group B Streptococcus], or proven in this pregnancy or if bacteruria then at risk then antibiotics. (M4, 14th meeting)
	You would ring the consultant and say "you need to come in. I have a woman having a breech who refuses to have a caesarean section". (M3, 14th meeting)
Eliciting verbal contribution	How much of yourself are you putting into this? (M4, 25th Meeting)
	What are you doing about the comments from neonates that the baby was lucky to survive? (M1, 14th meeting)
Providing information.	They should have given her glycerol trinitrate to stop contractions. (M4, 14th meeting)
	You must make an effort to get the relationship going; up to you to start building relationships. Make yourself known to them. Say "Hi, I am [name]". It is up to you to start building relationships. (M3, 14th meeting)
Engaging within the story by eliciting more information.	I wonder about the pain relief – it doesn't sound as if the epidural was effective if you were topping it up hourly. (M1, 20th meeting)
	I wondered what you expected the shift co-ordinator to do when you told her what you did. (M2, 12th meeting)
Making supportive noises and comments.	Well done from [name] and [name]! You have shown you can negotiate when you have enough information. (M1 &3, 14th

Type of response	Example of what mentor said
	meeting)
	I know my practice has changed over the years. When I went into independent practice I consulted a lot more for the same reasons you are talking about because of uncertainty about the system, or the problem was more advanced than I knew about and I need to talk with someone about this, I sent more [women for secondary consultations] than I do now. (M4, 14th meeting)
Giving parallel examples.	I had a woman who relayed a message like that to me and I was unable to help and the police charged her and the man ran away. (M3, 25th meeting)
	Getting clarity at this stage is really good; when I spent an entire night babysitting someone's baby while they had a sleep I knew I had overstepped my boundary; they were a young couple who were beside themselves. (M4, 25th meeting)
Challenging.	It isn't even what is normal but what the culture is – highly anxious and over reacting and you can see that becoming a part of your culture. (M3, 25th meeting)
	You see midwives trying to save women; all you can do, is be honest. (M3, 25th meeting)
Negative responses:	
Blocking and changing the direction of the conversation.	Equally you need to dissolve the relationship. (M1, 14th meeting)
	Trouble is [by visiting and making yourself available] they [women who have miscarried] may keep ringing you. (M4, 14th meeting)
Responses which positioned the mentor outside the actual issue.	People have lost the ability to look at the risk in context. (M3, 14th meeting)
	I am chairing. Do not plan a 'quick' postnatal before the group meeting. Before meeting plan something you have control over. (M3, 14th meeting)

I had never intended that the analysis would examine the language of the discourse between mentors and new graduates in microscopic detail. Instead my focus was on the broader aspects of the methods of mentoring being used, in order to give a description of what was going on at a more generic level. So, rather than exploring the individual transactions further at this point, I again stood back and re-read and listened to the threads of discussion of several whole meetings, trying to focus on the broader mentor approaches and what was going on in these interactions.

Responses Looked at in the Light of What the Mentors Were Trying to Achieve

This is where the position of the researcher as both insider and outsider became interesting. I had participated in these meetings and had found them dynamic and interesting, yet I was finding it difficult to characterise what was taking place. As a researcher, I found it difficult to make sense of what was happening in the meetings and this lead me back to read the transcripts again. Whilst reviewing the whole meeting transcripts and re-listening to the audiotape, I was struck by the engagement of the mentors, their different styles and the harmonic of the group.

Since the first phase had been looking at why new graduates brought concerns or issues to the meetings, it seemed sensible to now consider what might be motivating the mentors, in order to throw some light on their responses and interactions in the discussions. In the tapes, I heard evidence of the mentors' commitment to the quality of care that the new graduates provided (transparency, documentation, consulting, sharing concerns both professionally and with the women and their families), and a sense of the mentors' understanding and

encouragement of the new graduates. I also referred to what the mentors had said in their interviews about their expectations and understandings about mentoring (see Chapter 4).

With an understanding of the mentors' approaches in mind, I next began coding threads of dialogue from the original sample of six meetings to uncover what lay behind the mentors' responses to the practice stories which were presented. I began to ask myself questions about how the mentors around the circle engaged with the issues brought by the new graduates. I had previously noted how ordinary the surface responses by mentors appeared to be, but below the surface the responses showed the mentors' approaches to midwifery and mentoring. I coded the threads of conversation which exposed in their responses a particular approach to mentoring, and looked at the function that approach may have served. I then broadened the initial sample of meetings to include another 13 meetings. I had previously transcribed 20 meetings, and because the original sample had already been intensively studied many of the examples had been used. The meeting transcripts I used were the original six (1st, 9th, 14th, 20th, 25th and 29th) to which I added the 2nd, 3rd, 8th, 13th, 18th, 21st, 22nd, 23rd, 24th, 26th, 27th, 28th and 30th meeting transcripts.

Thinking about mentor motivations and considering the range of initial responses helped me to identify four broad categories of mentor responses:

- standing alongside the new graduate

- telling/directing/giving information/asking closed or leading questions

- non-directive open questions

- showing multiple perspectives/exploring/asking probing questions/opening out the discussion.

What follows are illustrations of these four types of response extracted from the content of the meeting transcripts. These examples are presented as Tables 8,9,10 and 11; they show more of the thread of the conversation, so that both mentor and new graduate contributions are presented.

Standing alongside

An example of standing alongside happened in the third meeting at the beginning of the mentoring year. The new graduate's concern was about her feeling silly phoning a mentor and her fear of "mucking up" clinically. These concerns were quickly and comprehensively addressed by the mentor, who spoke for all the mentors, as Table 8 shows.

Table 8: Example of "Standing alongside" (3rd meeting)

Speaker	Speech	Commentary
NG1	When I first rang the mentor, I felt silly but I am going to ring when I need to.	Self-reflection
M 4	You don't need to spend the next 6 months apologising, we really don't want you to do that.	Supportive-standing alongside
NG1	I feel really quite anxious at the moment I would hate to muck up.	
M 4	As mentors we will tell you if we think you are mucking up. We have made a conscious decision to stand by you and we know where you are because we have been there and we know what it's like and we know what to expect from you so you don't have to apologise we are with you and we want you to feel safe. We are all with you.	Supportive-standing alongside
NG2	It has been good this week.	
M 4	We have all been there and we will share some of our stories too if they help.	Supportive-standing alongside

This example shows a nurturing and deeply reassuring approach to a new graduate early on in the mentoring year. Later in the year the mentors were not quite so reassuring, but typically were reinforcing the new graduates' now well-established capacity and expecting more independent thinking and reasoning. An example of the change from the early nurturing response appears in a much later meeting in the dialogue thread. This is discussed in the next section, looking at multiple perspectives.

Multiple perspectives: exploring/asking probing questions/opening out the discussion

This type of mentor response was more challenging than the completely supportive "standing alongside" response. It involved mentors drawing out a range of different perspectives, by asking exploring or probing questions which served to open out the discussion. The story below (Table 9) emerges through explorative questioning from the mentors as they try to establish what exactly the new graduate's concern is; in the process, its complexity is unveiled. This example comes from later in the year, when the mentors expect the new graduate to be able to work out a plan of action based on the woman's clinical need and her right to informed consent, as well as on the new graduate's own uncertainty about her level of experience and the woman's increasing level of risk.

Table 9: Example of "Multiple perspectives" (29th meeting)

Speaker	Speech	Commentary
NG1	Now I have another situation; a planned home birth, now 42 weeks so I am not feeling good; had a profile which was normal, we had a consult with the Reg [Registrar] who came in and said home birth after 42 weeks is not safe, increased risk of meconium and decreased placental function, book in tomorrow morning for an induction but she says she feels like she is holding on and doesn't want to be induced.	Technical issue; issue self-reflection; issue to do with others
NG2	I've talked with her too and she was sobbing and is panicking.	
M1	How are you feeling?	Open question
NG1	I am not comfortable with her situation; I have supported her with everything, now she wants another stretch and sweep. I am coming off the back of 3 caesareans and a forceps. I don't want to muck up.	
M2	What will you do about her refusing the induction?	Open question
NG1	I have booked her in and said "no one will make you do it." I am scared of it happening at home, I am scared that the membranes will rupture just before the birth and there will be meconium and the baby will aspirate it.	
NG3	Have you told her that?	Closed question
NG1	I will talk to her about that; last night I was looking at the risks in the research literature.	
M1	Have you set your limits so she is clear where you stand and where your comfort levels are?	Closed question
NG1	No. After 42 weeks it should be a hospital birth according to Reg. The mother is happy to go to	

Speaker	Speech	Commentary
	hospital if she has to.	
NG2	Explained to Mum why the safety of baby and mother important and about my comfort levels.	
M2	As [Mentor] said good to put boundaries around your practice.	Directing
M1	What would you like to do?	Open question
NG1	I would prefer she was induced tomorrow or she goes into spontaneous labour and goes to hospital. If she hangs on until 43 weeks; I don't think I can support her.	
M1	So it sounds as though you do have a limit-where is that between 42 and 43 weeks?	Open question
M2	You need to have a sense of what is your bottom line; for example suggest she have the baby in hospital as your induction compromise and bottom line. I want you to have your baby in hospital no matter what because I am uncomfortable with you waiting for 43 weeks. Maybe ask her when she would be prepared to be induced.	Telling
M1	If that is what you want you could also see if she wants you to refer her to another midwife who is willing to provide post 42 week care at a home birth. Maybe a biophysical will give you more indications about where to go.	Telling
NG1	So far all investigations have been reassuring.	

The mentors here were using a range of open, closed and telling approaches to achieve a response in the new graduate which helped her to find some clarity in this dilemma, rather than staying confused by her lack of ease with the woman's point of view. The new graduates' lack of experience meant they were often meeting situations for the first time, and the dialogues between new graduates and mentors

were establishing patterns of clinical and critical thinking. Uncertainty is not limited

to new graduates, however; it is a constant in midwifery which is why developing

some clarity and honesty about one's own position, situation by situation, is

important to the women for whom we provide care, but also for ourselves and for

communicating with other health professionals with whom we work. In the scenario

above, the mentors were not imposing their thinking, but were trying a number of

angles to have the new graduate take a position or find a way forward with a practice

scenario which was frightening for her. It was the 29th meeting, the group was well

established, and the sense of safety in the process was well enough established that

this discussion could unfold quite straightforwardly without the new graduate

appearing defensive.

Telling/Directing/Giving Information

The third type of response is directive. It showed mentors asking clarifying closed

questions and then telling the new graduate what she could or should do throughout

the transcripts. The example presented in Table 10 below occurred just after midway

(July) through the mentoring year.

Table 10: Example of "Telling/directing/giving information" (20th meeting)

Speaker	Speech	Commentary
NG1	When you go into the hospital to do VBACs [vaginal birth after a prior caesarean section] because I have a woman who is having a VBAC next month can you use the birthing unit? Someone told me you have to monitor the woman constantly throughout the birth, is that right? That's not what I want to do. Can I put her in the birthing unit and not tell them?	Technical issue

Speaker	Speech	Commentary
NG2	Have you consulted?	Closed question
NG1	No she doesn't want to.	
M1	Have you documented that and recommended a consultation?	Closed question
NG1	No I haven't written that conversation down but I did recommend one.	
M2	Have you looked up the policy about it?	Closed question
NG1	No.	
M2	I suggest you go into the unit and read the protocol.	Telling/Directing
NG3	I know someone who had VBAC in the birthing unit.	
M1	Do you know why she had a caesar last time?	Closed question
NG1	For a breech.	
M2	You need to look at the policy yourself, manage the referral process well and establish what the woman wants. When you go in [in labour] you tell the co-ordinating midwife what has been done and what decisions have been made. You may need to monitor continuously.	Telling/Directing
M1	What do you want to do with her at the moment?	Probing question
NG1	I just want to leave her at home and labour naturally as long as possible and you know go in when she is well established. I don't know whether I scan again. I have six VBACs due in the next few months.	
M3	None agreed to a referral?	Closed question
NG1	One woman who did go in said she was just told she needed a luer in [Intraveous cannula] and had to be monitored continuously, but she didn't want that, so she couldn't see the point of going to see them.	
M2	If the policy says that you need to do those be sure she understands that and also that you have discussed the risks	Telling/Directing

Speaker	Speech	Commentary
	of a vaginal birth after a previous caesarean.	
NG1	Oh ok, I will look at that plan again and check the policy and discuss again with the woman.	

This dialogue thread shows the mentors mostly being both very directive and telling and asking closed questions. There is one instance where the mentor is using a probing question which is non-directive. This dialogue thread shows a small sample of what might be considered competing styles of mentoring which might not seem complementary, but this same mix of approaches persisted comfortably side by side throughout the year. Then there was an expectation that the new graduate was no longer "new" and she needed to make her own plans and attend to multiple perspectives. The group made it clear that she needed to seek out and be informed about the usual approaches before deviating in an unaware fashion. The mentors made it clear that the new graduate needed to discuss these with her clients, and if the client did not wish to follow the usual management, then the new graduate needed to document this and be clear about the woman's reasons and that both needed to be clear about the implications. There is no particular problem with wise alternative choices made for good reasons, but the mentors were concerned with the quality of the thinking applied to clinical management in this case. They were also concerned, in the interests of good practice governance, that any clients were fully informed that their choices were an alternative to usual practice.

A small interaction at the end of another dialogue thread also shows a mentor challenging a new graduate about the length of time she spent at a labour, "for me

you were there for too long. For whatever reason you were there too long I am not

blaming" (M3, 20th Meeting). Although the mentors were directive and challenging

at times, the tone of the meetings was positive and certainly the new graduates

considered these meetings highly valuable. The mix of mentoring styles exposed the

multiple perspectives from which any practice story might be viewed, and how

privileging a variety of viewpoints enables the practitioner to be honest and accept

and understand the reasons for their position.

Non-directive open questions

A less confronting approach, and one that is in many ways more

sophisticated, is the mentor's ability to ask open questions which elicit the new

graduate's knowledge. The following thread of dialogue (Table 11) was about a

meeting with the delivery suite co-ordinators, one of whom had been bullying with

the new graduates. The new graduates were given an opportunity to decide whether

they would come to the meeting or not. It was clear that they were uncomfortable

not fronting up, but it was also important that they felt safe to attend. It was

important that they explored the range of options.

Table 11: Example of "Non-directive open questions" (8th meeting)

Speaker	Speech	Commentary
M 1	Are you coming to the meeting at the hospital?	Closed question
NG 2	Mary's not sure whether we should go.	Issues to do with others
NG 4	I think if we don't go it's not very helpful.	
NG 1	We have said these things so we should front up.	

Speaker	Speech	Commentary
NG 4	Seems odd. I don't want to go but I feel we don't want to hide behind our mentors.	Self-reflective
NG 2	Mary is trying to be protective of us.	
M 1	I don't know why it would be harmful to go?	Open and probing question
NG 4	I feel weird about a meeting going on about us and not being there. If I was in the hospital person's situation then I would appreciate the group fronting up.	Issues to do with others
NG 3	Feels like we had sent the big sisters. Mary said it was up to us.	
M 1	Would you go if the other [new graduates] were too busy?	Closed question
NG 4	Yes, we are all people I am not going to play into the whole hierarchical thing.	
M 1	If that is your plan then it makes sense to go.	Telling

The mentor at this meeting was in the uncommon situation of being the only mentor at the meeting (this happened only once in 31 meetings); perhaps that meant it was much easier to make non-directive responses which elicited more commentary from the new graduates. At other meetings, however there were also examples of non-directive questioning, and these too were often interspersed with other mentors providing direction and telling. Table 12 shows this happening.

Table 12: Example of mixed categories of responses in a dialogue thread (24th meeting)

Speaker	Speech	Commentary
NG 2	I took it so personally and I got angry I understand she can change her mind. I still feel like I have done something wrong.	Self-reflection and issues to do with others

Speaker	Speech	Commentary
M 1	Can you explain why you feel like that?	Open question and probing
NG 2	I wonder if I didn't explain the labour process well enough.	
M 1	How does she feel about it?	Open questions
NG 2	She is sore and she is unhappy about that.	
NG 1	I was there and I was amazed how well [name] explained everything throughout. It's not your thing it is her thing and she changed her mind.	Issues to do with others
M 4	Did you try the authoritative approach? Jean Sutton said there are situations when you need to call on the fetal ejection reflex and you walk up and go "give me your baby". Sometimes this approach is appropriate used at the right time.	Directing/giving information

These threads of conversation from meetings illustrate all four types of responses. Throughout the meeting transcripts, there were often threads of conversation which had mixes of at least two of these types of responses.

Summary

This analysis has for the first time described what four new graduates were concerned about in their first year. It shows the new graduates as competent professionals, willing to accept responsibility, and at the same time trying, with the help of mentors and colleagues, to make sense of their working world and the feelings that it generated. Interestingly, many of the problems they appear to have are not with their clients or their skills, but with a hospital power structure; yet they consciously worked to create opportunities for collaboration and mutuality within

that structure, while also building their own ability to be assertive. The new graduates were also able to express their not knowing and inexperience quite candidly.

The mentors are shown to use different types of style and approaches. There are differences between mentors and also over time. Even when responding to the same issue, mentors sometimes use quite different approaches; but, as a result, the new graduates get to see different perspectives and to be supported, challenged and encouraged to reflect. All mentors encouraged approaches to birth which enhanced normal physiology, but they were also very clear about practices which were seen as potentially unsafe.

VI.   GROUP MENTORING – "CHALLENGE WITH LOVE"

The title for this chapter is taken from how one new graduate described her group mentoring experience. At the outset of this study, I was uncertain that group mentoring would work. My ten-year experience of mentoring new graduate midwives was always in a one-to-one relationship; I was unsure about how four mentors, working together in a group, could effectively provide the level of support I knew four new graduates would need. My experience was that the first year in practice was extremely stressful for most new graduates. I had known some new graduate midwives who had thrived, but others who had left the profession or experienced so much stress that their marriages suffered or dissolved. Although I thought the idea of a group approach was an interesting one, I was quite sceptical about whether a group would "hold" the new graduates well enough for them to trust everyone and share their experiences openly, or whether it would be safe in testing circumstances. Thus, as a researcher and participant, I had a number of concerns when the project began: whether a group approach would effectively support the new graduates for what is a difficult transition from student to autonomous midwife practitioner; the possibility that conflict might emerge within the group; or that a critical incident would occur which would break the group apart.

As it turned out, I enjoyed what evolved into a dynamic and harmonious group where experiences were shared by the new graduates and where mentors responded with their wisdom and with kindness. Varieties of opinion about clinical management between the mentors were often openly discussed, and the new

graduates said that these inter-mentor dialogues added to their learning experience. The mentors too found this lively discussion interesting and enjoyable. Just as my expectations around being part of a mentoring group differed from the reality, so too I found much in the research which I also did not predict. In this chapter I discuss what I found and the implications for mentoring practice and for further research. The chapter is divided into the following sections:

- whether the group mentoring model achieves what is expected from mentoring

- new graduates: sufficient, able, and confident

- differences that the group made

- strengths and limitations of the research

- recommendations for mentoring practice in midwifery and elsewhere

- my conclusions.

Whether the Group Mentoring Model Achieves What is Expected From Mentoring

The group mentoring model that has been researched in this thesis was established as a pragmatic response to a practice need. Four willing and experienced midwives found a way to meet the mentoring needs that four new graduates had identified, without the mentors having to be always individually available. The group model was in this way quite different from the usual New Zealand one-to-one mentoring model for new graduate midwives. The aims of the research were to describe a new group mentoring model in detail and to explore whether group mentoring supports new midwives to gain confidence. A second aim was to discover how the group

mentoring model enables experienced midwives to support and pass on practice knowledge and wisdom to new graduates.

In this section I use the findings that have been presented in the previous two chapters to argue that the group mentoring model achieved what mentoring of new graduate midwives is expected to achieve, and that the aims of the research have been met and I discuss what seem to be some of the key aspects in that achievement.

Group Mentoring in Terms of Formal Definitions

In this section, I consider whether the group mentoring model did achieve what mentoring is usually expected to achieve, by comparing it first to the definition of mentoring used in the research and the NZCOM Consensus Statement on Mentoring (New Zealand College of Midwives, 2000) (Appendix B).

In Chapter Two, I presented and discussed the definition of mentoring used in this study, which was "a voluntarily agreed professional support activity in which the person being mentored is an active partner, their needs are the focus of the mentoring, and the intention is to assist and cultivate their professional confidence". Here I consider the constituent parts of this definition in turn, in relation to group mentoring.

The group mentoring model was by definition a professional support activity. A "professional support activity" refers to a quality of thinking as well as acting. Both are important, particularly when mentoring new graduates and one mentor expressed her view that: "I strongly support the notion that midwives get mentored … particularly self-employed practices … so I support it both philosophically and

from a practical point of view of getting new people, new blood coming into your practice and into your community" (M4, 2nd Interview). Mentoring well was a source of pride for the mentors, who realised they were "… role modelling, that kind of behaviour … and that kind of philosophy, the absolute belief that says my standard of practice is that I'll have a commitment to the future of midwifery and to the wider community" (M4, 2nd Interview). There was in the group a sense of the importance of providing high quality midwifery, including that it was sustainable, communications and actions were clear, and midwives' practice showed that they were critically reflective.

Group mentoring was also very clearly "voluntarily agreed" since, as already described, it was initiated by a request from the new graduates, and the details of the model were jointly developed by and agreed to by the new graduates and the mentors. This included the new graduates choosing their mentors, even in a time of midwife mentor shortages. The Government announced funding for a Midwifery First Year of Practice (MFYP) programme the following year, and that programme maintained the importance of each new graduate choosing their mentor (Ministry of Health, 2007a). Two years later, an evaluation of the MFYP programme found that graduates' "choosing their own mentor" encouraged trusting partnerships, and was identified as facilitating the effectiveness of the relationship (Oliver, 2008, p. 8). It was clear from the initial interviews in this study that these new graduates were seen (and saw themselves) as independent and responsible professionals who were fully involved in establishing how their group mentoring programme would work.

According to the definition, "the person being mentored is an active partner and the needs of the person being mentored are the focus". These aspects of the group mentoring model came through very strongly in interviews and from analysis of the meetings. In their first interviews, the new graduates clearly saw that they would be the ones who would seek support from the mentors when they needed it, and the analysis of the logs of new graduate-mentor contacts bears out that this was indeed what happened. The meeting analysis demonstrates that the topics discussed were mostly those that the new graduates chose to discuss. In fact, the new graduates were so much the active partners in the model, that at their mid-year interviews, the mentors expressed some unease about aspects of the new graduates' practice management, and wondered whether their responsive approach might have been too non-intrusive.

The definition of mentoring includes a statement that "the intention is to assist and cultivate their [the person being mentored] professional confidence". The interviews with mentors made it clear that this was explicitly part of the model in the minds of the mentors. Mentors carried a sense of the importance of this professional role too, and as one said "I absolutely see it as a professional responsibility to look after new grads, mentors and mentor practice" (M4, 1st Interview). Similarly, the new graduates identified in their first interviews that they felt inexperienced and lacking in real world knowledge, and they expected that mentoring would support and assist them to become confident practitioners.

The NZCOM statement about mentoring goes further than a simple definition and describes some expected attributes of mentoring. This statement says

that "the mentor listens, challenges, supports and guides another midwife's work. A mentor does not always give answers but encourages the mentored midwife to research, explore and reflect on her practice" (New Zealand College of Midwives, 2000). The analysis of the mentor responses in the meeting transcripts shows many clear examples of when mentors listened, challenged, supported and guided the new graduates. The four types of mentor responses that were identified illustrate each of the skills mentioned in the NZCOM statement. The mentoring group provides an ideal forum for mentors to share their practice wisdom and fulfil the second aim of the research. When the mentors' responses were of the "standing alongside" type, they were supporting the new graduates. When they were "exploring and asking probing questions", they were challenging the new graduates. When their responses involved open questions, they were listening carefully to the new graduates and helping them think beyond the immediate and obvious. Sometimes they were guiding the new graduates by responses that were "telling, directing or giving information", but the mentors' preferred response was to "stand back".

Mentors Encouraged Critical Thinking and Confidence

The ability to support the development of confidence and critical thinking seemed to all four mentors to be extremely important. Conversations between mentors about how to provide this balance of support and challenge, focused quite specifically on non-interference, listening well and providing affirmation when appropriate. One mentor described the approach as "sort of a non-interference concept, of being able to listen when called … let the new graduates take their own decision except that we

have interfered at various times when we have felt we needed to" (M1, 3rd Interview). In many ways the mentors developed their confidence in the new graduates along with the new graduates' increasing their professional capacity. Mentors also were unstinting in their willingness to be available for advice, assistance, information or discussion when they were on call or attending the weekly meetings. There were times when giving information and advice was appropriate but when it was possible to listen and ask facilitative questions they knew they were more likely to be stimulating critical thinking. One new graduate admitted that when she rang an on-call mentor she often finished the conversation needing "to think about this more because I have been encouraged to think about it more" (NG2, 2nd Interview).

The mentors understood that holding back on telling or giving information encouraged critical thinking in the new graduates; this meant that mentors needed "to be able to stand back and say 'well, what would you do' and then 'yes, well that would be okay, you could do this, or this, or this is what I would do'" (M3, 2nd Interview). Learning to listen is important as a midwife but the mentors, all experienced midwives, were aware they needed to hone their listening and facilitation skills even further.

One mentor commented that mentoring was often misunderstood and required being at "one removed; instead of engaging with the thing and wanting to solve the problem. I think most people think that mentoring is giving advice" (M3, 2nd Interview). She expressed her own struggle with this position and what she thought might help, "So I will work a bit more on where they're coming from. I

mean that's very hard and I think I need – that's what mentors need training to do"
(M3, 2nd Interview). One mentor found the process easy in retrospect, just to ask
"'what would you do'? And it's so successful" (M3, 2nd Interview). She thought the
new graduates made good decisions and that trusting them worked well. When she
was impressed by their decision making she let them know, by saying "I think that
[plan for providing care] is absolutely fine – I think that's a really good decision that
you have made" (M3, 2nd Interview). The mentors were concerned about how this
approach of being available but not interfering without being asked would work, but
they were reassured "…they do make good decisions. They are doing really well.
They are doing fabulously. I'm actually blown away by where they are at" (M3, 2nd
Interview).

Comparisons with the mentors' own, admittedly different, path to midwifery
autonomy showed that these new graduates were "…really stunning and much
better… than I was at the same stage" (M3, 2nd Interview). Even so, it took time to
learn to hold back: "[I] should have asked her first what she thought she should do
before I offered advice" (M2, 18th January, 2006 Mentor Log). Sometimes the
mentors felt quite badly about their performance when providing face-to-face
mentoring: "I felt pretty useless actually and did not feel that I was of much help at
all and just increased the anxiety of the doc and the midwives and myself" (M2, 14th
March, 2006 Mentor Log). The new graduates practised in ways which the mentors
found reassuring: "[Name] is very capable and with [name] with her they make a
great team and very competent" (M2, 14th March, 2006 Mentor Log).

Mentors Used a Variety of Helping Styles Within a Developmental Mentoring Model

How the mentors responded to the different conversation threads showed a variety of helping styles: "standing alongside", "telling, directing or giving information", "non-directive open questions", or "multiple perspectives, exploring and asking probing questions". These four types of responses can be looked at in terms of Clutterbuck's (2009) two dimensions of helping, described in Figure 1 (p. 45). The "telling" and "non-directive open questions" fit at either end of Clutterbuck's directive and non-directive dimension; the "standing alongside" and "exploring multiple perspectives" fit to Clutterbuck's nurturing and stretching dimension.

The mentors were all very aware of being reassuring, but also acknowledged a responsibility to explore the new graduates' clinical decision-making and, when appropriate, encourage more sophisticated considerations about their clinical management. The range of mentor interactions, from reassuring to challenging, is similar to those of Clutterbuck's dimension of mentors' behaviours from nurturing to stretching (Clutterbuck, 2009, p. 16). An example from Chapter Five of reassuring (nurturing) responses showed a mentor speaking to a new graduate about how the mentors were "standing alongside" her, and that no question was "too silly" to ask or bring to the meeting. The reassurance in this example was very strongly expressed, but this strong reassurance became less important as the year progressed and the new graduates came to know the mentors better. The mentors remained committed to support throughout the year, but initially, when we were an unknown quantity, stronger verbal reassurance was appropriate. A balance needed to be found between

being supportive and being challenging, and at different times throughout the year, what was appropriate changed.

The second dimension of mentor responses, very like Clutterbuck's "directing or non-directing" dimension (Clutterbuck, 2009, p. 16), was telling or directing the new graduate to "do" something, or alternatively, being non-directive which was a more enabling stance. In Chapter Five an example is given of the mentors responding to a clinical situation by telling, directing and giving information, because in that case critical thinking and good judgement were pivotal to safe clinical management. The new graduate presented a situation she was about to encounter to seek out the mentors' opinions; the mentors' responses were unequivocal in their direction and advice giving. But at the other end of the spectrum, there were cases where mentors deliberately chose not to intervene, but rather facilitated the new graduate to find her own way. As with midwifery so with mentoring the mentor responses were situation specific though the values and principles were shared: "On the open field of practice, in the everyday situatedness, there are multiple, and at times, conflicting meanings of 'being safe'" (Smythe, 1998, p. 252). These decisions were not always easy, as one mentor reflected during her interview at the end of the project:

> …obviously mentoring is a big learning experience – learning how to tailor your advice-giving to be able to ask the questions to the mentees in the way that will enable them to think and reflect and come up with the answers themselves. Umm…some challenges some great experiences, loved it. (M2, 3rd Interview)

For a mentor knowing how to intervene in a new graduate's work takes knowledge and care in order to achieve the right balance of appropriate support. This ability to manage one's concerns as a mentor and encourage confidence has to be based on responding honestly, particularly if you are concerned about what you are seeing in practice. "How to do this mentoring thing is difficult – too often want to take over rather than get in behind – especially when I think the behaviours are not comfortable" (M2, Mentor Log, 18th February, 2006).

Mentoring as a professional activity is largely about how mentors speak with the new graduates. It is sometimes more important to ask good questions, with the hope of generating critical thinking, than to give advice. Although giving advice can be useful, it can prevent the new graduate from thinking through their own actions. The ability of mentors to flexibly move along the spectrum from standing alongside to probing and challenging marks sensitivity to the new graduate's needs, and an ability to match the mentor styles to the need. Therefore as one would expect, the mentor responses, though more challenging later in the year than early on, were still mixed throughout the year, depending on the situation.

The closer that the responses were to the nurturing and directive end of Clutterbuck's dimensions of helping, the closer the styles were to a sponsorship model rather than a developmental model of mentoring (Clutterbuck, 2009, p. 20). Sponsorship mentoring is about a style of teaching and learning which is built on reciprocal loyalty, rather than learning opportunities and friendship (2009, p. 20). In other words, the sponsorship model of mentoring is a more parental rather than adult-to-adult relationship. These differing models (developmental and sponsorship)

of mentoring capture differing approaches to offering support and using power which, according to some writers, appear to be more about the culture than the individual. According to Clutterbuck, and supported by other research from New Zealand (Chiles, 2006; Clark, 2004; Clutterbuck, 2009), the developmental model is better suited to the UK, Australian, New Zealand and Canadian cultures. The developmental model is when the "power and authority of the mentor are parked" and the mentoring "begins with an ending in mind", built "on learning opportunities and friendship" and where the "most common form of help is stimulating insight" (2009, p. 20). The participants in this study clearly identified their group mentoring as an example of the "developmental model", where the new graduates were the active partners and determined their learning needs. However, those needs and the mentor responses were negotiated, and it was through this process that the relationships within the group were fostered and flourished.

The strength of the group may have been due a number of factors, including: prior relationships between the individuals within each group; the respect for practices between mentors, which, although based on a normal birth philosophy, shared enough difference to be of interest to one another as well as to the new graduates; and most importantly the ability to examine one's own and others' practices dispassionately. The mentors were senior midwives who were comfortable acting as experienced peers and parking their power and authority; however, the helping dimensions of standing alongside and telling, were also evident. As the new graduates were autonomous midwives in their first year of practice, these more "parental" positions were at times also appropriate, but were mixed with other more

open or indirect or challenging positions at other times, in order to stimulate the new graduates' own thinking and insight.

Summary: How the Group Mentoring Model Worked

Although the group mentoring was not the typical one-to-one mentoring relationship, in every other respect it met the definition of mentoring and the mentors behaved in ways that were consistent with the accepted New Zealand model of mentoring. This model of mentoring was premised on values of adult learning where the new graduates were the active partners in the relationship (Knowles, 1973, 1980). The mentors demonstrated a variety of helping styles, ranging from supportive to challenging, and non-directive to directive. The group mentoring model fits well with the developmental mentoring model that is widely supported in New Zealand and achieves what is expected of mentoring in line with that model.

New Graduates: Sufficient, Able, and Confident

In this section I look at what I have found about the new graduate midwives' needs, and the part that the group mentoring model played in their developing confidence. I discuss how new graduates are best viewed from a perspective of sufficiency rather than deficit, and how they understand their own support needs and access support from peers as well as from mentors. I also consider what developing confidence means in the context of first year midwifery graduates.

New Graduates: Deficient or Sufficient?

Research on new graduates' needs is mostly from international nursing literature. and in general, references others' assessment of their needs rather than those expressed by the graduates themselves. New graduates are generally seen as inadequate compared with their more experienced colleagues, and this judgement, instead of stimulating support, marks them as deficient. In some studies, this is explained by their being unprepared for registration because of inadequate pre-registration education (Li & Kenward, 2006), or because of the theory-practice gap making them clinically deficient and in need of learning technical skills or training in critical thinking (Del Bueno, 2005). The view is that new graduate nurses (which sometimes means midwives) "…assume professional responsibilities that potentially are beyond their capabilities" (Dyess & Sherman, 2009). Nursing studies show that this concern about the adequacy of nursing graduates was typified by a recent survey of hospital and health systems nurse executives in the US, who believed only 10% of "…their new graduates were fully prepared to provide safe care" (Berkow, Virkstis, Stewart, & Conway, 2009, p. 17).

In New Zealand, newly registered midwives are considered competent at the point of registration (Midwifery Council of New Zealand, 2007). The competencies, which are important for practising autonomously in New Zealand, are expected to be achieved by registration. This standard is set by the Midwifery Council of New Zealand, charged under legislation to provide an assurance of public safety (Health Practitioners Competency Assurance Act 2003 2003).

The new graduates in the present study clearly viewed themselves as competent and self-sufficient although they also recognised that they were inexperienced, understood their limitations and valued the ability to contact mentors when needed. Most of the 85 contacts occurred in the first half of the year (76 calls); this fits with the experience of other commentators on mentoring both inside and outside midwifery (Clutterbuck, 2009; Kensington, 2005). In total the three new graduates practising during the first six months called a mentor to come in and be with them whilst they attended a client on 15 occasions; there was one other such call in the second half of the year. Given these new graduates cared for about 50 women during their first six months, 15 calls for assistance seems a relatively small number of times to provide support to midwives who were fully responsible for their case-load for the first time. Of interest also is the fact that in the second half of the year, the overall number of contacts with individual mentors was not only smaller but the calls were most often to discuss a situation rather than asking for advice or for the mentor to attend.

The view of these new graduates as sufficient rather than deficient is supported by what the mentors said in their interviews, as well as in their logs of contacts. The value scores that the mentors gave in their mentor logs confirm that the new graduates were making appropriate use of the mentors. None of the 85 contacts were considered by mentors to be inappropriate or of poor value and 80% of them were assessed as being good or very good. There was never a time where the mentors felt they should have been called and were not. On only one of the 16 times that mentors provided support for a new graduate with a client was this

support critically important; on that occasion, the two new graduates managed the clinical emergency (severe shoulder dystocia at a home birth) well.

Many of the discussions in the group meetings also support the new graduates' competence and knowledge, even while they were presenting issues where they felt inexperienced or were dealing with situations that they found difficult. There were very few occasions during these discussions where mentors had to correct a new graduate's knowledge, or recognised a situation where a new graduate was recounting an inappropriate or omitted action. In terms of being contacted by or assisting new graduates, there were no situations where a mentor felt that the new graduate had done something wrong or omitted something important.

This study supports the New Zealand situation, in which new graduate midwives are held to be sufficient and competent for independent practice, and ready to accept clinical responsibility. The new graduates themselves saw and accepted this, while also seeing the importance of having mentoring support to help with their transition as inexperienced practitioners into the working world. The four experienced mentors in the present study also clearly saw these new graduates as sufficient rather than deficient practitioners.

New Graduates Know Their Needs and Get Help From Mentors, Peers and Others

The new graduates' competence and sufficiency was also demonstrated in the way that they were able to take control of their own learning needs, recognise when they needed support, and choose where to get it. This was shown from before the year started, since it was they who saw their need for mentoring, initiated the request to

the four experienced midwives, and negotiated how the group mentoring model would operate. During the mentoring year, the new graduates were the ones who decided when they would call for mentor support or advice, or whether they would seek assistance from others. In terms of the group meetings, it was the new graduates who decided the frequency of the meetings, what matters would be discussed, and for how long the meetings would continue over the year.

During the analysis of the interviews and meetings, all four new graduates remarked on the value of having the support of their peers. The value of peer networks has been noted in nursing literature, and in some places is formally incorporated into new graduate programs (Proulx & Bourcier, 2008, p. 51). In the present study, the new graduates set up their own peer support network early in the new graduate year, by providing labour care for women in pairs. The new graduates also frequently called one another and shared their daily practice experiences. Peer support between beginning practitioners has been shown elsewhere to provide a boost for new graduate confidence (E. S. Scott & Smith, 2008).

The new graduates often sought advice, asked for help or made referrals to other practitioners for the women for whom they were caring. Many of the discussions at the group meetings were prompted by issues to do with these relationships with other practitioners amid the technical concerns of the work itself. These discussions show that the new graduates were learning how best to approach these sometimes difficult interactions with others amid making critical clinical decisions. In a study of group supervision of Norwegian midwives the "opportunity to debrief during supervision helped them develop the courage to reflect and assume

responsibility in difficult situations" (Severinsson, Haruna, & Friberg, 2010, p. 406). Despite the fact that new graduates were talking about midwifery work, their interface with colleagues was a more striking feature of their concerns than was the interface they had with their clients (Mackin & Sinclair, 1998). Since the new graduates chose what would be discussed at the group meetings, it is clear that these were the relevant learning needs and concerns that arose in their practice experiences. This demonstrates that in a safe and confidential learning environment, questions about the culture in which they were becoming immersed could be asked, and they could learn about approaches to working within the new working world in which they found themselves.

The most common reason for issues being discussed in the group meetings was categorised as "technical" – often involving technical questions to do with how the system operates, as well as clinical questions. "Issues to do with others" and "reflections about self" were the second and third most common type of reason for matters being discussed; these very frequently arose from thoughts and feelings about situations involving other practitioners. In Kram's (1980) study of one-to-one mentoring in the business world, she described two main functions of mentoring: "career or instrumental" and "psychosocial" functions. In the present study the "technical" matters that the new graduates brought to the meetings can be seen to be similar to Kram's "instrumental" function, and the other two categories, "issues to do with others" and "reflections about self", can be aligned with Kram's "psychosocial" function. It is of interest that the present group mentoring model reflects Kram's mentoring functions, even though the present study is about a

profession rather than the business world, and involved a group rather than one-to-one mentoring. It may be that the current model was designed to meet the needs of the person being mentored, so the functions served are similar, because the person's needs in all mentoring situations are similar.

In some other professions, such as occupational therapy and medicine, shadowing or being attached to a clinical mentor can have mixed results, because of placing unnecessary limitations on the new graduate's autonomy (Berridge, et al., 2007; Lee & Mackenzie, 2003). Conversely, when, as in midwifery in New Zealand, the new graduate is competent on obtaining her registration and she is fully responsible for her case-load, then her ability to seek help and know that this help is willingly forthcoming at any time or place is paramount. She then avoids the problems and sense of dependence arising in situations where professionals are clinically supported, but have limitations placed on their capacity to practise autonomously (Lee & Mackenzie, 2003). One of the advantages of being autonomous is the clarity about the responsibilities of the new graduate. In addition, she needs to be well supported either individually or within a group of willing professionals. When a new graduate is able to choose from whom, when and how this support is provided and negotiates according to her preferences, she is maintaining a good deal of clarity about herself and her future plans and directions. This certainty about her role and her ability to seek help, as and when needed, creates a support structure that is, importantly, clear and transparent.

Developing Confidence

The overall purpose of the project was to encourage and support the new graduates to develop confidence. The importance of new graduates gaining confidence should not be under-estimated. Sometimes it is easier to assess the value of professional confidence by exploring its negative aspect. The international research literature reports the consequences of diminishing confidence as: increased anxiety (Berridge, et al., 2007; Reardon & Ferrall, 2006); lower retention rates (Beecroft, Santner, Lacy, Kunzman, & Dorey, 2006; Lee & Mackenzie, 2003); an increase in burn-out (B. McKenna, et al., 2003); and reduced self-esteem and job satisfaction (Casey, Fink, Krugman, & Propst, 2004; McPherson & Barnett, 2006; Steenbergen, 2004).

A link between confidence and job satisfaction was made in an Australian study about occupational therapists: "Participants highlighted that professional support could assist in developing independence and other skills. However, ultimately a lack of support resulted in decreased confidence and subsequent decreased job satisfaction among participants" (Steenbergen, 2004, p. 160). In Britain, Curtis et al., (Curtis, et al., 2006a) found job satisfaction for midwives entailed work which provided three important conditions: autonomy, flexibility and support. Sadly many UK midwives have left the profession because of the limitations placed on their capacity to practise and these limitations, according to Kirkham (1999), leave midwives with a prevailing sense of powerlessness. This was not the experience of midwives in this study who could work to their full capacity as autonomous midwives, who managed their own client load, and were supported by

their peers, mentors and a network of colleagues which they developed over the year. Importantly they individually used the on call facility quite differently and according to their needs, for example, one midwife called twice as often as two others but did not ask for her on-call mentor to attend to the same degree.

The first year in practice is described by a study of New Zealand new graduate nurses as a "confidence-building phase" but a study into horizontal violence indicated that 34% of the 551 nurses who participated in the research experienced "rude, abrasive, humiliating or unjust criticism" (B. McKenna, et al., 2003, p. 94). The reported effects of this behaviour on new graduates in that study were increased absenteeism and serious psychological sequelae for the individual nurse (B. McKenna, et al., 2003). In the present study, following experiences of bullying, a change in culture was observed by the graduates after a meeting was held between the mentoring group and the hospital staff.

As with other studies that explore the experience of new graduates, the present study used the participants' own expressions of confidence or loss of confidence as a measure (Berridge, et al., 2007; Casey, et al., 2004; Davis, Foureur, Clements, Brodie, & Herbison, 2011; Lee & Mackenzie, 2003; Reardon & Ferrall, 2006). Although the new graduates in this study 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 3, page 129). This finding that confidence grows over the first year of midwifery practice, was also reflected in a recent

Australian study (Davis, et al., 2011). The rates of confidence were explored using a self-reported rating scale (1-10), of how confident they felt in "working to the 14 'National Competency Standards for the Midwife' and the International Confederation of Midwives (ICM) Definition of a Midwife" (Davis, et al., 2011). My interest was sparked by how this paper found a low score at the end of the year, in how confident the midwives felt about working to the ICM definition of a midwife. The New Zealand scope of practice and model of care for all LMCs, which includes new graduates, ensures that the ICM definition of a midwife is fulfilled (Midwives, 2005). In Australia there is a perception that models of continuity of care ought to only be available to experienced midwives, but the authors (Davis, et al., 2011) argue that the continuity of care model of maternity care is appropriate for new graduates so long as these graduates are well supported. This present study and the evaluation of the MFYP programme would seem to reinforce the veracity of that argument (Oliver, 2008).

Confidence grows with experience. Confidence and experience are the interdependent variables needed for practice. Benner's definition of experience is useful here: it "…is not the mere passage of time or longevity. Rather it is the transformation of preconceived notions and expectations by means of encounters with actual practical situations" (Benner, 1982, p. 11). In the group mentoring model, these encounters were multiplied by the new graduates' partnering one another at births and by attending the group meetings, where the numbers of experiences presented by colleagues increased the exposure of each new graduate to discussions about and actual practical situations. Moreover, the new graduates were

able to reflect on these experiences in the safety of the group of both new and experienced practitioners.

Confidence is defined as "belief in one's own abilities" (Collins, 1990, p. 202). In *The Odyssey,* a story is told of the Goddess Athena visiting Telemarchus in order "to embolden him" (Homer, 1945, p. 23). This tale seems to me to give a sense of what building confidence means to new midwives. In particular, the new graduates took time to feel "emboldened" about the nature of their interactions with other health professionals. Forming mutual and respectful relationships with other midwives and other health professionals are one of many challenges new graduates face. On one occasion in this study, a new graduate early on in the year, did not explicitly ask an on-call mentor to assist although that is what she wanted, and later realised it was her own lack of self-confidence that made her diffident to ask. Therefore, confidence is important for new graduates, even when the best and most responsive mentoring is available, in order that they ask for help appropriately. It importantly affects competence according to a recent study which suggests "competence without self-confidence is insufficient" and the "acceleration of confidence development in new graduates assures their accelerated competence acquisition is applied" (Ulrich et al., 2010, pp. 373-374). A lack of self-confidence can impair the capacity of new graduates to ask for help in the best of supportive situations, and it is therefore unsurprising that when new graduates are not well supported they feel powerless and leave the health workforce. Therefore responsiveness and supportive mentoring programmes are essential to enhancing the capacity of new graduates to recognise their needs and ask for help. However in this

study, as their first year of practice progressed, the findings show new graduates had all developed a capacity for assertiveness and mutual dialogue. According to the literature (Casey, et al., 2004; Lee & Mackenzie, 2003), this is typical of many new graduates.

In the study's findings there are examples of assertiveness such as one midwife who delayed a non-urgent induction until the next morning to allow a tired client and the midwife a chance to get some sleep overnight, but happily the woman gave birth naturally overnight. For another midwife assertiveness was shown by demanding an appropriate consultation by an obstetrician who seemed to her set on not attending to the reason for the referral to him, and instead seemed set on humiliating the new graduate. There were many examples of the new graduates' asserting themselves as registered midwives to request help or information when appropriate, and being discriminating in finding the appropriate assistance. They attended antenatal clinics with clients they had referred there for obstetrical oversight, in order to meet obstetricians and establish respectful colleagial relationships as well as for supporting their clients.

Summary: New Graduates, Sufficient, Able, Competent and Becoming Confident

The findings paint a picture of new graduates who were already competent and well-prepared for independent practice; were able to recognise their own inexperience and see that they needed mentoring support; used the availability of both the one-to-one contacts and the group meetings to meet their learning needs – particularly in the

areas of relationships with other professionals; learning how the system operated and steadily gained in confidence and assertiveness over the course of the year.

Differences That the Group Made

Although this group mentoring model achieved what is expected of mentoring, and supported the new graduates to become confident practitioners, it is important to consider what difference it made that this was a group process, rather than a one-to-one relationship. In this section I look at group relationships, determining that whilst they are less personal than one-to-one, they can have other advantages not possible with one-to-one relationships. I consider the advantages provided by being able to see a range of mentor approaches and interactions, and how, to some extent, this accurately reflects the new graduates' working world. I also look at the importance placed on the group meetings, and how the meeting environment created a group harmonic which provided a "stimulating sanctuary" for the new graduates to develop within.

Relationships, Partnerships and Variety

Group mentoring is a different approach from that of one-to-one mentoring. Although in the group mentoring model both meeting as a group and meeting one-to-one were available to the new graduates, intimacy, which is generally regarded as one of the defining characteristic of one-to-one mentoring, was less evident than in the one-to-one mentoring relationships I have previously experienced. The partnership in the group mentoring model was between the two groups, the new

graduates and the mentors, rather than between individuals. The opportunity for one-to-one contact was always available to these new graduates, and they did make one-to-one contacts 85 times over the year. In addition, personal sharing did occur, both in the meetings and in one-to-one conversations, but the level of intimacy was less than can sometimes be experienced in a one-to-one mentoring relationship that lasts over a year.

However, one-to-one relationships are not always intimate or even successful (Long, 1997), and the present model has positive gains for those individuals who find relationships within groups easier than one-to-one relationships (Zachary, 2010). Responding to an individual's need is one of the two core variables Clutterbuck believes informs mentoring (outside the USA) and the lack of this might be seen as a limitation to group mentoring (2009, p. 15). However, within this mentoring group, individuals' professional needs were expressed in one-to-one calls for support and at the group meetings where individual's issues and concerns were raised.

The group provided a range of differing perspectives and professional values that it is likely many new graduates are not exposed to in a one-to-one system of mentoring. These differences in perspectives and professional values between mentors at meetings, enriched the new graduates' experience and understanding. New graduates were exposed to an expanded number of possible perspectives on each clinical scenario they discussed, and sometimes could see mentors taking different positions. To some extent, this diversity mirrored the new graduates' place as self-employed midwife practitioners within a health-service, rather than as

midwife practitioners with a few practice colleagues working in isolation. The difference between these two positions can begin to be addressed within a group of mentors collaborating together and sharing differing perspectives. Learning how to collaborate within one's own profession sets the stage for taking on a professional persona as a midwife and increases professional connectedness.

The graduates managed to accommodate the differences between their mentors well because the mentors maintained respectful relationships. The individual mentor differences were less important than a shared normal birth philosophy. However, the different mentors' health sector experience meant that the situations and practice stories brought to the group were viewed from a broad range of perspectives. The new graduates were encouraged to maintain respect for a variety of different views. Values evident throughout the project were respect for others and encouraging openness in the midwives' discussions with women and other colleagues. The nuances attached to thinking and acting independently and maintaining respectful relationships within the maternity service, across primary and secondary care, were present within the new graduates' stories told at meetings.

Helping to Create a Group Harmonic and a "Stimulating Sanctuary"

Although new graduates lose the closeness of a one-to-one relationship, a group may be preferable for learning about being a professional and about being socialised into a professional culture (Ritchie, 1999; Ritchie & Genoni, 2002).

The group engaged early on in the year in a workshop on the use of particular processes to facilitate their in-depth reflections on professional practice.

When the group was formed, the new graduates and mentors shared a mentoring training workshop about reflecting on professional practices in a group. The training also reinforced the capacity of the two groups to negotiate the mentoring process, despite our differences in experiences in midwifery. There is a good deal of research evidence on the need for all health workers to have the opportunity for reflecting on practice, for improving the quality of nursing care (Butterworth, 1992); promoting interpersonal communication in multi-disciplinary teams (Hrykas, 2001); developing general practitioner appreciation of the complexity of relationships with patients (Wilson, 1999), and for empowering midwives (Kirkham, 1999). These studies all refer to the use of reflection within clinical supervision, however the findings in this study shows that reflecting on practice occurs in mentoring in midwifery too (Kensington, 2005; 2006{Lennox, 2009 #355) There exists a vast body of knowledge of reflective practice that lies outside the scope of this thesis. The new graduates regularly reflected on their practice as is evidenced in the findings. The aim of this naturalistic study was to describe in detail the group model of mentoring by representing as accurately as possible, the real world experience. Importantly though, reflective practice is closely associated with improving quality and safety in nursing (Bishop, 2007, 2008; White et al., 1998; Winstanley, 2000a, 2000b).

The new graduates in this study valued having a protected space for reflecting on their practice, and this supported their development of critical thinking skills and their confidence. Although the new graduates valued all the support that was offered to them (24/7 on-call access to a mentor), in their end of year individual interviews, they unanimously acknowledged the group meetings as the most helpful

part of the process. The group met very regularly during the year, and this may also have been one of the strengths of the process. In one evaluation of one-to-one mentoring the regularity of meetings between the mentoring partners seemed to have the most impact on the success of the relationship (Beecroft, et al., 2006, p. 743). The meeting process was structured and this pattern was repeated over time and maintained the group's sense of direction and purpose each week. The structure of the storytelling (reflective) process over the year had a ritual element which functioned as a still point in the week, no matter how hectic or chaotic the lives of the individuals within the group had been (Appendix K). This structure anchored the group for the meetings but also provided a blueprint for them for the future. This process was repeated by the new graduates for their own meetings.

Whilst the analysis of the interview and meeting transcripts shows the new graduates' sense of satisfaction with the mentoring group, it remains difficult to capture the harmonic that was experienced by the participants. How that occurred can only be hinted at through the evidence from the whole of the data analyses. The new graduates showed a capacity to be very honest about what was going on for them throughout the year, with both their struggles and their successes. There is also confirmation of their capacity for thinking before they called the mentors or anyone else with whom they consulted. Along with their honesty and general capacity for thinking about their work, they were confronted with the life and death realities of their responsibility very early on in their first year. This too offered an opportunity for the group to convene and unequivocally support the new graduates.

The mentors held the value of mentoring (and midwifery) very highly, and on first meeting the new graduates, engaged with their enthusiasm and capacity to assert themselves and with their vision of midwifery. All the new graduates said they "felt safe", "looked forward to those meetings" and found them "helpful". They also enjoyed the fact that the mentors all approached practice somewhat differently; they felt that this left them with the freedom and the responsibility to find their own practice style.

What was not captured in the analysis was the amount of laughter at the meetings each week – which made transcribing the tapes difficult at times. Some of the mentors' stories, which arose in response to new graduate stories and as "what this reminds me of" responses, left us weeping with laughter, and this was not an infrequent occurrence. Various other matters, for example, to do with weight issues, new clothes and holidays were discussed in the "chat" before we began our meetings, and all this promoted a culture of safety and trust. These were some of the unstructured and spontaneous ingredients which supported the serious job of mentoring and beginning practice, and over time created a harmonic where serious questions could be asked without fear or recrimination.

The new graduates found freedom in these meetings with their mentors to critically discuss their concerns and to feel safe to do so, creating what one writer described as a "stimulating sanctuary" (Pegg, 1999). The elements to good mentoring, which Pegg called the "Five C" model, involve helping others by focussing on "challenges, choices, consequences, creative solutions, and conclusions" (Pegg, 1999, p. 136). Pegg argues that good mentors "create a

stimulating sanctuary", but that these conditions are possible only when both parties, the mentored and the mentors, actively work together (Pegg, 1999, p. 136).

The word "sanctuary" has ancient connotations of a holy place, a consecrated shrine and a place of refuge where protection is assured (Collins, 1990). The conditions for such a sanctuary required time and commitment from the new graduates and the mentors. The process of confidence building that is so important for new graduates was supported by establishing such a sanctuary. This sanctuary was constituted by all eight participants collaborating to create a space which was both safe (with assurances about confidentiality) and stimulating (safe to challenge and be challenged). The process of confidence building and the process of the group forming seemed at times to mirror one another, as the participants discovered the boundaries to their shared relationship. The sanctuary was a safe place, maintained with mutual respect and open communication, where challenges were accepted as part of the process of mutual negotiation. This was a place where the new graduates felt safe enough to talk about their experiences, thoughts, feelings, failings, achievements and confusion about their new role as accountable and responsible practitioners. The findings from this group mentoring study suggest that the group meeting structure enhances the quality of practice conversations, encourages the use of the meeting process for conflict resolution, and increases collegiality amongst new and experienced professionals. The possibility now exists for other mentoring groups to be formed and for new graduate practitioners or others to gain the advantage of multiple perspectives on practice.

Strengths and Limitations of This research

This research is the first detailed study that has used recordings of mentoring conversations to look at what actually happens in the meetings between new graduate midwives and their mentors. The developmental model encouraged the active participation of the new graduates, in order that their concerns were heard and discussed with experienced mentors. These mentors were chosen by the new graduates and were available to them for regular meetings and were on-call 24/7 for as long as needed over their first year. It is a detailed study of a model of group mentoring which could be used in a variety of different professional or business fields.

The research is richly descriptive. It has drawn on a range of data sources designed to observe the phenomenon from several perspectives and increase its reliability. My position as both participant and researcher has allowed me to have an insider view and the collection of data concurrently with the group mentoring project has supported my ability to understand the meaning of the material.

As with all research of this type, the findings will resonate with those interested in the field, and the insights gained as a result may be applied in other settings enriching the value of this research. The descriptions of how the group was established, the structure of the overall process, the on-call arrangements and the group meetings are useful to anyone considering setting up a group model of mentoring.

It is impossible from this study to say reliably whether the model was safe and effective in terms of the outcomes for the women cared for by the new graduates. The model has shown that these new graduates gained confidence over the year. A simple comparison of aggregated statistics of births showed that the outcomes for the women they cared for during the year were similar to those cared for by all midwives in their local district (Appendix L). The model was also shown to be manageable for the mentors, who were able to adequately answer queries and attend clinical settings, despite having other work commitments.

There is a risk in times of mentor shortages of inappropriately applying the findings of this model of group mentorship by using one midwife mentor to mentor many new graduates. This would be a serious safety risk, both for the new graduate midwives and for the women to whom they were contracted as LMCs. It would also lose the advantages of the knowledge held within the group when the numbers of new graduates and mentors are either equal or close to equal. The numbers of mentors and new graduates may not need to be exactly equal but any variation would need to maintain the small group dynamic and the ability for relationships of trust to be established within the group.

Recommendations for Future Research

The success of this group mentoring model means that it can be recommended for mentoring new graduate midwives, and it provides direction for future research. This study was focused on the history of mentoring, its functions and models, and the suitability of these models for new graduate mentoring in New Zealand; it presents a

new approach to graduates in place of what I have called "the deficits model" and fills a gap, which currently exists in the research on the needs and concerns of the new graduates and "how best we can support them to develop as strong and confident practitioners through their first year of practice" (Davis, et al., 2011). Finally this research describes an innovative model of mentoring for new graduate midwives and one which has not appeared in the literature up until now. This naturalistic and descriptive study opens up new fields of research possibilities.

In New Zealand, the arrangements and funding for the Midwifery First Year of Practice Programme could be available to new graduates and potential mentors who wish to establish a mentoring group. There may also be situations where the group model is used where there are insufficient individual mentors available to be on-call 24/7, but those available would be prepared to work in a group alongside other mentors and share the on-call commitments. This could be part of a pilot programme with a built-in evaluative component, one which compares one-to one mentoring with group mentoring in order to determine the new graduates' preferences and the reasons why.

A self-evaluation framework could be embedded within the group (or one-to-one) mentoring that required that the new graduates write a short description of any new learning from each of the mentoring sessions. This could also include a between-session understanding or realisation which may have developed as a result of a previous mentoring discussion. This could also be done on-line (password protected) by the new graduates, and if they agreed, used for research purposes. In addition, research could be focused on furthering an understanding of the

development of confidence in practice. Rather than using a single measure snap-shot like the Visual Analogue Scale, it would be useful to use a more comprehensive and detailed scale such as the "Confident Midwife Profile"(Ministry, 2009). This profile could be used as a basis for answering reflective questions (perhaps on-line) at particular points throughout the first year so that the new graduates could better recognise the changes to their understanding. This data would allow researchers access to those reflections, if agreed to by the graduates, and provide further insights into how practice learning and confidence develops over time.

Group mentoring along the lines described in this study would be suitable for supporting new graduates in a number of professions. In particular, group meetings based around structured discussion of new graduates' practice stories could become a more widespread part of career development support for graduates. Such meetings would be valuable throughout many professional practices, and not only in early years.

Another aspect of the group approach is that mentors themselves have support and can learn from one another and this aspect of the experience needs further study. I intend to explore the data on the mentors' experience of mentoring in the future. More analysis of recordings of group mentoring meetings might reveal whether some mentor responses are more effective than others. This might require detailed discourse analysis

Much further research could and should be done into group mentoring. For example a larger study to compare group and one-to-one mentoring models in order

to explore how important the intimacy of a one-to-one relationship is to new graduates. The midwifery practice culture of persecuting new graduates was found within this study as has been observed in other studies (Kensington, 2005). In this study the group provided a sanctuary with high support and were able to challenge this behaviour with good effect. Further research must be done on exploring the finding that a mentoring group model can create a circle of support where persecutory behaviour is successfully challenged and the culture improved. The use of Quality Learning Circles has been researched amongst school principals in New Zealand for over a decade (D. Stewart, 2000). This is a sophisticated approach to reflective group practice "where shared professional narratives are illustrated with evidence of practice" within and across schools (D. Stewart, 2008). The focus of this work is on interactions amongst people and these are used as both the development activity and as raw data for the research. This work resonates with the concept of communities of practice which is another body of knowledge associated but outside the scope of this thesis. This concept has been criticised as reducing learning and knowledge "to participation, privileging reflection and social interaction over cognitive learning, and thereby minimizing the importance of content learning" (Berry, 2011, p. 13). I propose that professionally supportive relationships, like mentoring, within the health workforce are the key to encouraging and enhancing quality and safety; thereby promoting a culture of trust, curiosity and learning.

Conclusions

This research examining the mentoring of new graduate midwives was ambitious and covered a broad landscape, but focused on three features: mentoring, the needs of new graduate midwives, and the use of a group approach. Each of these features has individually been the subject of other research, but to my knowledge there has been no other research on group mentoring of new graduate midwives. The research found that this model of group mentoring provided the four new graduate midwives with a safe "sanctuary" where they were able to explore the challenges of practice. The new graduates thought that their confidence had increased and that this was helped by working in peer pairs, having a mentor always on-call in their first six months and, most importantly, having regular and frequent group meetings involving both new and experienced practitioners. This has the advantages of exposing the new graduates to multiple perspectives, encouraging them to understand and build collegial relationships, and creating a safe and stimulating place for them to build their confidence.

Group mentoring was also found to be effective and efficient from the mentors' point of view (less time on call, providing less opportunity for cloning or for creating dependency or disappointment). The shared practice narratives from the combined repertoire of four experienced midwives provided the new graduates with more understanding of the professional world of midwifery. This is a model that deserves to be widely available as an option for new graduate midwives who wish to be mentored.

I have participated in one-to-one and group mentoring as a mentor and enjoyed both, but the advantages of a group to the mentors are undeniable: less individual time is needed, and there is less individual responsibility, which is much more relaxing when sharing what is a very responsible and exacting role if performed well. The advantages of a group for the new graduates include being less close to one practitioner, for better or worse, and as a result, finding it easier to develop their own style of practice. They also become better informed about more potential clinical scenarios than are possible through being mentored by one person. The opportunity in a group to maintain close working relationships with their peers is another advantage that should not be underestimated. This has the advantages of exposing the new graduates to multiple perspectives, encouraging them to understand and build collegial relationships with colleagues, and creating a safe and stimulating place for them to build their confidence.

This research has international significance as an innovative approach to supporting new graduates by using a developmental model of mentoring. The assumption of competence at the point of registration changes the quality of support which is appropriate to offer in the first year of practice. The new graduate midwives in this study showed that, far from being deficient in skills, they were alert to their needs, engaged with meeting them and with any other learning which improved the quality and safety of their practice. This model of group mentoring has been shown to support the emerging capacity of four new graduate midwives as self-reflective and confident practitioners.

Appendix A: Contract Between Group Members

GROUP MENTORING PROJECT 15TH MAY 2006

PURPOSE OF THE CONTRACT

This is a contract between the following 8 people:

MOAS	CAPITAL MIDWIFERY COLLECTIVE

We four, [Mentors' names], will be available on a roster 24 hours a day 7 days a week to respond to requests from the Capital Midwifery Collective (CMC) for midwifery mentoring (whatever forms that may take-see definition below).

Definition of Mentoring as it is to be practised in the Group Mentoring Project

- Weekly meetings at a mutually agreed location

- One MOA (Extinct New Zealand bird) on call each week 24/7 to respond to call from any four of the Capital Midwifery Collective (CMC)

- Group Mentoring Development (peer mentoring workshop, skills training, orientation to delivery suites etc)

- Participation in professional forums; e.g. New Zealand College of Midwives meetings, attending DHB collaborative and other meetings (mortality and morbidity) and Wellington Midwives Society (WMS) mentoring meetings

- Active participation in the research which will describe and evaluate the group mentoring project and write it up for publication in various formats (the project has received ethical approval from the Human Ethics Committee of Victoria University of Wellington September 6, 2005).

- Any other activity as the need arises and the group decides to participate

1.1 Boundaries and Limits for MOAs

The MOAs will attempt to stick to a timetable which we will make available to you. We have the first six months timetabled.

Changes on the night or any time will be notified to you by the person changing their day on, by pager and if possible, email.

1.2 Boundaries and Limits for Capital Midwifery Collective-no additions made

PAYMENT

The GST will be subtracted because we won't be making enough to claim the GST as a group from this MoH money. We have to be very clear about how we spend this money which is part of the report back expectation from Ministry of Health. We

need to be able to justify however we use this money; for example, only doing course which are NZQA or Midwifery Council of New Zealand (MCNZ) approved.

GROUP PROCESS FOR MEETINGS

The eight midwives mentors and mentorees attended a peer mentoring workshop in February 2006 in an effort to enhance our group processes of sharing and learning in a supportive environment.

MANAGEMENT OF CONFLICT

In the first place we will use the NZCOM Code of Ethics and Standards for Practice as our guide for discussion and resolution. Failing successful resolution a third party may be called on to facilitate or provide professional supervision. This cost may be met by members of the group from the group's mentoring fund.

LIMITS TO CONFIDENTIALITY

Confidentiality is assured about both the identities of clients and the midwives. Many incidents will be shared and these will remain within the group. The researcher will use scenarios presented to her from a variety of sources such as: from the Reflections on meetings (Sheet 1), Portfolio Stories (Sheet 2) which will be used also for the mentorees midwifery standards review at the end of her first year of practice, from the weekly taped meetings, also from the interview tapes and finally from the mentors log sheets. The details *may* need to be fictionalised to show only those features needing to be described for the purposes of the thesis and to honour the agreement that these remain non- identifying.

The researcher *may* also be using events from within your clinical experiences but with the same due care and respect.

At the end of the year outcome statistics will be collated and analysed together and almost certainly used in a variety of ways: for arguing the case for mentoring in the first year of independent practice, in presentations at conferences and in journal articles and in the final research transcript or PhD. These outcome statistics will not be identifiable according to the midwives concerned because they will be aggregated to improve confidentiality.

The limits to confidentiality are those behaviours which are contrary to New Zealand legislation in particular the Health and Disabilities Code of Rights, Midwifery Council of New Zealand regulations and the Code of Ethics of the New Zealand College of Midwives.

6. BIRTH PLANS

We mentors wish to have our role clear in the Birth Plans of the mentorees' clients who will understand our purpose as support persons or mentors, for the mentorees.

SIGNATORIES TO THE CONTRACT:

[Signed by mentors and new graduates]

Signed off on the 15th May 2006

Appendix B: Consensus Statement New Zealand College of Midwives

---

NZCOM CONSENSUS STATEMENT

Mentoring

This Consensus Statement was ratified at National Committee meeting 27 September 2000

The mentoring relationship is one of negotiated partnership between two registered midwives. Its purpose is to enable and develop professional confidence. Its duration and structure is mutually defined and agreed by each partner.

A mentor listens, challenges, supports and guides another midwife's work. A mentor does not always give answers but encourages the mentored midwife to research, explore and reflect on her practice.

The mentored midwife remains responsible and accountable for her own practice in accordance with statutory obligations of a registered midwife.

Guidelines:
Who is a mentor midwife?
A midwife who:
- is registered and currently practising midwifery
- is willing to undertake the mentor role
- has demonstrated practice which reflects the midwifery model and has participated in the NZCOM Midwifery Standards Review

The kind of attributes needed in a mentor are:
- being a good listener and communicator
- having commitment to the development of midwifery practice
- knowing maternity services well and being up to date with changes taking place
- having the ability to work effectively in partnership with women

A successful mentor will:
- be available at regular intervals
- support efforts of the mentored midwife
- influence midwifery practice in a positive way
- help develop the mentored midwife's sense of confidence

The mentored midwife can expect the mentor to:
- challenge her on issues affecting her midwifery practice
- identify strengths and weaknesses
- assist with identifying ongoing educational and practice needs
- encourage her to become active in midwifery networks

Please Note:
The New Zealand College of Midwives' Ethics outline the midwife's responsibilities to colleagues and the profession. The College has no expectation that mentors receive financial benefits. However:
- Any financial arrangements are optional and negotiated between the midwives concerned.
- Mentoring can be time-consuming. The mentor should have the time available to commit to the mentoring relationship.

Appendix C: Transcriber Confidentiality Agreement

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

Study of Midwifery Mentorship

Transcriber Confidentiality Agreement

I agree to treat the contents of the audio tapes that I am transcribing confidential.

I will not reveal the contents of the transcripts to anyone other than the researcher

Sue Lennox and/or her supervisors Professor Maralyn Foureur and Joan Skinner of

the Graduate School of Nursing and Midwifery

Signed ………………………………………….

Date …………………………………………

Appendix D: Interview Schedules

Interview 1	Sep – Dec 2005	~35 mins duration
New graduates	How do you imagine the group operating throughout the year? What strengths do you imagine you will offer the group as a whole? What is your biggest fear? What are your visions of the year for you and for the group? What are your short, medium and long term goals?	
Mentors	Why are you doing this project? Do you have any concerns?	
Interview 2	**Jun – Jul 2006**	**~50 mins duration**
New graduates	Tell me about your first few months of being a midwife? How does the reality of being mentored compare to your expectations? How have you found the group process? When you contacted the mentors individually how helpful were their responses? Score (1-4) the overall quality of one-to-one communications with mentors where 1=poor, 2=fair, 3=good, 4= excellent. What have you learned that is new to you?	
Mentors	I revisited each individual's previous concerns Are you concerned that the mentors have only met once as a separate group?	
Interview 3	**Oct – Dec 2006**	**~ 90 mins duration**

Interview 1	**Sep – Dec 2005**	**~35 mins duration**
New graduates	Of all the mentoring support processes what was the most important for you? How has this been important for you? What did you learn? What would you like to change? How were the weekly meeting for you? Each participant asked about their life story: How would you which describe your life story and its influence on your becoming a midwife?	
Mentors	How has the project gone? What comments (negative and/or positive) would you like to make about the idea of group mentoring?	

Appendix E: Mentor Logs

DATA TO BE GATHERED ON A LOG SHEET BY MENTORS

1. Name of Mentor
2. Date of contact
3. Time contact began
4. Time contact completed
5. Who contacted you? Eg a mentored midwife, doctor, hospital, path lab etc
6. Reason for contact- describe in detail
7. Did this require an in-person consultation by you? Yes/No
8. Who requested the in-person consultation? Mentor or Mentored midwife or Other (list)
9. Outcomes of the consultation – describe in detail

MIDWIFE MENTORING PROJECT: MENTOR LOG

Please enter your answers in the grey boxes (they expand as needed)

Mentor's Name	
Name of the key people involved (click in one or more boxes)	NG1 ☐ NG2 ☐ NG3 ☐ NG4 ☐ Other ☐ Explain:
Date of Contact (dd MMM)		Time of Contact (24 hour)	
Length of contact (hh:mm)		Type of contact	

Travel	Yes ☐	No ☐	
Distance travelled (kms)		Total travel time (mins)	

Overall Value Score: 4 = very good; 3 = good; 2 = fair; 1 = poor	

Reason for contact (brief description of main reason for contact)

Mentor's action (brief description of what the mentor did or said)

Comments

LEGEND for mentors' log

Mentor Name	
Mentoree Name	
Date of contact	Day/month
Time of contact 24 hour clock	0100-2400
Length of contact	2-90 minutes
Types: Ph,, meeting with mentoree alone, meeting Mentoree and Client	Phone calls x 2 (calls) Should you phone another mentor midwife to discuss could you write Ph x1 + Mentor or name of mentor e.g .R x1 or Sx1 Mentoree (M) or M+C .All call outs will usually start with a phone call of course but I hope to count all contact(s).
Travel yes or no	Do you have to leave where you are to go to see the M or the M+C?
Total distance travelled (kms)	Estimation of time taken to travel from where you are to meet the mentoree and distances travelled. (the legend does not provide the rationale for each data collection point- this goes in the accompanying explanation/rationale section of your thesis and in a

	document for the mentors to know why they are collecting different types of data.
Reason(s) for contact (brief description of main reason for contact)	
Mentor action (**brief** description of what the mentor did or said)	Legal advice from the College suggests some ways of approaching our mentoree/mentor relationship. 1. The mentorees are not obliged to follow our recommendations. 2. We will contract to have our role clear in the Birth Plans of the mentor's clients in order that the client's will know that our role is as support for the mentoree. 3. What we say to the mentoree is important for many reasons including legal ones. For example giving stories from your own practice: "my response in a similar situation might be..." or if you are distancing yourself from the mentor's poor clinical decision making, you might say: "that would not be my choice of action". Please check the NZCOM consensus statement http://www.midwife.org.nz/index.cfm/Consensus,
Value Score	This is the most problematic column at present. I am trying to gauge your honest sense of the conversation, not whether what you said was brilliant but **how well you felt the communication went** –did she sound as if what you said met her concerns-

	maybe it would be good to ask her (then or later).
	A study in Britain showed what the midwife mentors thought the mentorees felt about the call was way off how they felt at the end of it. It is not whether your response worked In the event but instead, within the call and conversation.

Appendix F: Human Ethics Application

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

HUMAN ETHICS COMMITTEE

Application for Approval of Research Projects

Please write legibly or type if possible. **Applications must be signed by supervisor (for student projects) and Head of School**

Note: The Human Ethics Committee attempts to have all applications approved within three weeks but a longer period may be necessary if applications require substantial revision.

1   NATURE OF PROPOSED RESEARCH:

(a) ~~Staff Research~~/ Student Research (delete one)

(b) If Student Research   Degree PhD Course Code MIDW691

(c) Project Title: A study of midwifery mentorship

2   INVESTIGATORS:

(a) Principal Investigator

Name: Sue Lennox

e-mail address: Sue.Lennox@vuw.ac.nz

School/Dept/Group: Graduate School of Nursing and Midwifery

(b) Other Researchers   Name   Position

……………………………………………………………..

………………………….

………………………………………………………………..

………………………….

(c) Supervisor (in the case of student research projects)

Professor Maralyn Foureur

Joan Skinner

3   DURATION OF RESEARCH

(a) Proposed starting date for data collection:

September 1 or after ethics application approved

(Note: that NO part of the research requiring ethical approval may commence prior to approval being given)

(b) Proposed date of completion of project as a whole: December 2008

4   PROPOSED SOURCE/S OF FUNDING AND OTHER ETHICAL CONSIDERATIONS

(a) Sources of funding for the project

Please indicate any ethical issues or conflicts of interest that may arise because of sources of funding

e.g. restrictions on publication of results

The midwives being mentored pay their mentors for their time and expertise as is normal practice. I have discussed the potential for

alternative funding with the Ministry of Health and am awaiting the outcome of those discussions. Neither of these potential funding sources will restrict publication of results.

(b) Is any professional code of ethics to be followed   **Y ☑ N ☐**

New Zealand College of Midwives Code of Ethics

(c) Is ethical approval required from any other body   **Y☐ N ☑**

If yes, name and indicate when/if approval will be given

5   DETAILS OF PROJECT

Briefly Outline:

(a) The objectives of the project
   1. This project will address a gap in the research by exploring and developing an appropriate model/theory for mentoring beginning midwives within a midwifery practice focussed on a normal birth paradigm.
   2. Explore how mentoring newly graduated midwives into independent practice encourages, protects and promotes safe, normal birthing.

The study involves a group of 5 newly graduated midwives who are beginning professional midwifery practice in February 2006, and a group of 4 experienced midwives who are their mentors. The 9 participants will meet weekly to discuss practice issues. The 4 experienced midwives will take it in turns to be available 24 hours/day and 7 days per week to respond to any practice issue that arises for the new midwives. This may

involve telephone or email contact or in-person attendance by the mentor to support the new midwife.

The researcher is one of the experienced midwives who will be a mentor as well as leading the research.

This study has several aims. The first is to explore how mentorship of beginning midwives enables them to gain confidence. Secondly, to examine whether a particular model of mentorship, with a focus on keeping birth normal, empowers the midwives to safely resist the pressures inherent in the current risk averse environment. Thirdly, to evaluate the impact of mentoring on a group of mentors to better inform the process of midwifery mentorship. Implicit in the aims is the presentation of a thesis that will inform national and international policy in the area of midwifery workforce development. The thesis may also contribute to theory development in midwifery.

(b) Method of data collection

The study consists of 5 inter-related projects:

Project one:

Between September 2005 and February 2006 all nine participants will be interviewed (semi-structured) to explore expectations of mentors and mentorees. The interviews will be audio-taped and transcribed (see information sheets, consent forms and transcriber confidentiality agreement).

From September 2005 to January 2006, monthly meetings will take place to mentor the student midwives *into* practice. The researcher will keep a reflective journal of this process for analysis.

Project two:

Commencing in February 2006, hour long meetings will take place each week to discuss aspects of practice. The weekly group meetings will be run by the mentorees (although if necessary the researcher will maintain chairing rights if a learner centred approach is not followed). The researcher will make notes after the meeting of the main issues discussed. Meeting notes will be in the form of colour blocks shaped by the researcher and later transferred onto an excel spread sheet to discover how much of the meeting time is related to the mentorees' interests in clinical, physiology, personality, or social issues within practice.

The meeting will also be taped digitally and transferred to the computer. This will provide a backup if the meeting notes made by the researcher are not sufficiently detailed to enable interpretation. The researcher will also quantify how much of the talking time the mentors take and the focus of their comments. The data from project two will provide a quantitative and qualitative basis for working out the process of the interaction and the learning about mentoring in midwifery. This is a major source of data for the study.

Project three:

Each experienced mentor midwife will have a data sheet (attached) to record when in her week on-call she is called and about what, whether she went to the mentoree to assist her in practice and whether that was initiated by the mentor or mentoree and any other comments they wish to

make. This provides both qualitative and quantitative data for analysis and will enable costs of mentoring time to be calculated.

Project four:

Two interim and one post-mentoring interview will be conducted with all nine participants to explore their responses to the experience of group mentoring and their views about the limitations of the process.

Project five:

The mentorees will provide a copy of the clinical outcomes data and satisfaction survey responses of the women in their care in the comprehensive and non-identifiable format used by the New Zealand College of Midwives Midwifery Standards Review process.

(c) The benefits and scientific value of the project

This study will contribute to workforce development strategies for the midwifery profession both nationally and internationally. It will inform the NZ Government policy makers as to the potential pecuniary and clinical benefits of mentoring for midwives and women/families in New Zealand. It will significantly contribute to midwifery theory and therefore practice.

(d) Characteristics of the participants

In May 2005 at a meeting of the New Zealand College of Midwives an invitation was made to those present to volunteer to mentor a group of five midwives who were seeking mentorship for their first year in independent

midwifery practice. This stimulated several exciting ideas about mentoring and being mentored and inspired me to think about how this could be constructed as formal research that could have important implications for the whole of the profession. In talking with my colleagues, I found a group of four like-minded, expert midwife/academics who were prepared to provide the mentoring and who were willing and eager to join as research participants. This is a rare moment for research to be conducted as feminist praxis, which is the philosophical foundation of midwifery.

Therefore the 5 mentored midwives will be newly graduated from a bachelor of midwifery programme in New Zealand and will practise midwifery in Wellington.

The 4 mentors are experienced midwives who practice midwifery in Wellington. The researcher is also one of the mentors. The two PhD co-supervisors are also part of the mentor group. My four interviews will be undertaken by the PhD administrative supervisor Professor Jan Duke. The administrative supervisor will also be available for any issues which arise which are unable to be met by normal supervision processes. This has been discussed with the chair of the HEC.

(e) Method of recruitment

All 9 participants have already volunteered to take part in this study.

(f) Payments that are to be made/expenses to be reimbursed to participants

As mentioned previously the payment for mentoring is the responsibility of the new midwives and is generally paid out of their birth fee. The setting up and conduct of the mentorship is not part of the research design. The mentorship arrangement is happening in the real world and therefore provides an opportunity for my role as a researcher to describe and analyse how this happens from a variety of perspectives. There is no payment made to any research participant in relation to the research.

(g) Other assistance (e.g. meals, transport) that is to be given to participants.

None.

(h)   Any special hazards and/or inconvenience (including deception) that participants will encounter

The research participants will all experience some inconvenience in taking part in interviews. I will endeavour to keep that to a minimum by arranging the interview to take place at a time and location that is most convenient to them. The mentors will experience some inconvenience in having to complete a data collection form in relation to every interaction they may have with the mentored midwives. I will explain this clearly in the information sheet and obtain informed consent for the mentor's participation in this aspect of the research. I will endeavour to keep the inconvenience to a minimum by making the data collection form as simple to use as possible.

As the midwifery community in New Zealand is quite small (around 1000 practising independent midwives with around 90 in Wellington where the research is located), it may be possible for the participants to be identifiable to the local midwifery community. The local community will know which midwives are being mentored and by whom, since we will from time to time be interacting with the local midwifery community as part of our midwifery work. I will endeavour to protect the identity of the participants through using either aggregated or non identifiable forms of data in any presentation or publication arising from the thesis. All participants will be asked to keep the details of the research confidential in line with the ethical standards of the New Zealand College of Midwives.

(i) State whether consent is for (delete where not applicable):

(i)   the collection of data

(iv)   use for a conference report or a publication

(j) How is informed consent to be obtained (see sections 4.1, 4.5(d) and 4.8(g) of the Human Ethics Policy)

(ii)   The research is <u>not anonymous but will be kept confidential,</u> and informed consent will be obtained through a signed consent form (include a copy of the consent form and information sheet)

Y ☒ **N** ☐

The midwifery community is small in New Zealand, just over 2,000 midwives so the identifiably of the group of mentors and midwives will be possible. However the details of individual results, quotes or information used and described within the study and all publications arising will be non-identifying.

(k)   If the research will not be conducted on a strictly anonymous basis state how issues of confidentiality of participants are to be ensured if this is intended. (See section 4..1(e) of the Human Ethics Policy). (e.g. who will listen to tapes, see questionnaires or have access to data). <u>Please ensure that you distinguish clearly between anonymity and confidentiality</u>. Indicate which of these are applicable.

(i) access to the research data will be restricted to the investigator

Y □ N ☑

(ii)   access to the research data will be restricted to the investigator and their supervisor (student research)   **Y ☑ N □**

(iii)   all opinions and data will be reported in aggregated form in such a way that individual persons or organisations are not identifiable

Y ☑ N □

(iv)   other (please specify)

(l)   Procedure for the storage of, access to and disposal of data, both during and
        at the conclusion of the research. (see section 4.12 of the Human Ethics Policy).
        Indicate which are applicable:

    (i)   all written material (questionnaires, interview notes, etc) will be kept in a
        locked file and access is restricted to the investigator   Y☑N☐

    (ii)   all electronic information will be kept in a password-protected file
        and access will be restricted to the investigator   **Y ☑ N ☐**

    (iii) all questionnaires, interview notes and similar materials will be
        destroyed:

        (a) at the conclusion of the research   **Y ☐ N ☑**

    or (b) __5____ years after the conclusion of the research   **Y☑N☐**

    (iv)   any audio or video recordings will be electronically wiped

        Y ☑ N ☐

(m)   Feedback procedures (See section 7 of Appendix 1 of the Human Ethics
        Policy). You should indicate whether feedback will be provided to
        participants and in what form. If feedback will not be given, indicate the
        reasons why.

    Feedback in the form of a transcript will be provided to participants after
    each of the interviews for them to read and make comment. They will
    each be provided with a copy of the final thesis if they indicate on the
    consent form that they would like one.

(n)   Reporting and publication of results. Please indicate which of the following are
        appropriate. The proposed form of publications should be indicated on the information
        sheet and/or consent form.

    (i)   publication in academic or professional journals   **Y☒ N☐**

(ii) dissemination at academic or professional conferences   **Y** ☒ **N** ☐

(iii) deposit of the research paper or thesis in the University Library

(student research)   **Y** ☒ **N** ☐

Signature of investigators as listed on page 1 **(including supervisors) and Head of School.**

NB: **All investigators and the Head of School must sign before an application is submitted for approval**

……………………………………………

Date……………………...

……………………………………………

Date……………………...

……………………………………………

Date……………………...

Head of School:

………………………………………….   Date

………………………..

Appendix G: Information and Consent for Mentored Midwives

MENTORED MIDWIVES

Participant Information Sheet for a Study of Midwifery Mentorship

Researcher: Sue Lennox: Graduate School of Nursing and Midwifery, Victoria University of Wellington

Thank you for volunteering to participate in this research project which aims to explore the mentoring of 5 beginning midwives into their first year of independent midwifery practice by 4 experienced midwives. The main aim of the study will be to develop a model or framework for the mentoring of midwives in New Zealand. A second aim is to establish how to mentor midwives into safe, normal birth practices thereby fulfilling the midwifery mandate of "guardians of the normal.

As you know I am a PhD student in Midwifery at Victoria University of Wellington. As part of the degree I am undertaking this research project which will lead to a thesis. The University requires that ethics approval be obtained for research involving human participants.

This information sheet will set out clearly what data you will be asked to

contribute to the research, prior to the start of the mentorship year, during

the mentorship year and at the end of the mentorship year.

Mentorship will occur in two ways: during weekly group meetings between

the 5 mentored midwives and the 4 mentors; through individual mentoring

of each midwife as she identifies a need for consultation or in-person

support. The mentorship is the subject not the object of the research. This

means that you determine how the mentorship occurs. This is not set by me,

the researcher. My research role is to describe how mentorship happens and

to analyse and interpret what happens. In order to do that I am seeking your

assistance in the following ways:

1. Undertake 4 interviews of one hour duration each;
   a. The first interview to take place between September or October 2005 to ask you to describe what are your expectations of the mentorship year (sample questions are attached);
   b. A second interview three months after the commencement of the mentorship year (April, 2006) to ask you to describe how the experience of mentorship has been so far (sample questions are attached);
   c. A third interview six months after the commencement of the mentorship year (July, 2006) to ask you to reflect on how the mentorship year has been so far (sample questions are attached);
   d. A fourth and final interview at the completion of the mentorship year (September, 2006 or when completed) to ask you to reflect again on how the mentorship year was for you (sample questions are attached).

- The interviews will take place at a time and location that is mutually convenient to you and to me;
- You will be asked to choose a pseudonym for the interviews in order to assist in maintaining your non-identifiability.
- The interviews will be tape recorded and transcribed by a transcriber who will sign a confidentiality agreement not to reveal any of the contents.
- I will return the transcripts to you to check for accuracy of the comments you have made and ask you to amend any you feel are inaccurate.
- I will undertake a thematic analysis of the transcripts which will form part of my thesis.
- I may choose some of the comments made by you to illustrate the themes I develop however; you will not be identified in any of the material used.
- Only my supervisors Professor Maralyn Foureur (and Joan Skinner when Maralyn Foureur is away) the second supervisor and I will see the transcripts of the interviews. Since the transcripts will have pseudonyms attached, only I will know the true identity of the midwife.

2. The weekly group meetings will be audiotaped and the tapes may be transcribed. I might undertake a thematic analysis of the transcripts and some comments may be used to illustrate those themes. I will also take notes after the meeting in order to monitor the content areas that are discussed during the meeting. No names will be used in the transcripts of these tape recordings or in my notes.

3. I will ask you to provide me with an anonymised (both you and the reports of women's outcomes are non-identifiable) copy of your Midwifery Standards Review (MSR) Documentation including the non-identifiable women's satisfaction survey results. This will enable me to ascertain to what extent the mentoring process has enabled the midwives to deliver safe, normal birth services. I will use aggregated data only in the final write up of the thesis which means all 5

mentored midwives MSR documentation will be reported as a group and no individual midwife will be identified in any way.

Should you feel the need to withdraw from the project, you may do so without question before September 2006. Withdrawal from the research project will not compromise your participation in mentoring process.

All data collected will form the basis of my research project and will be put into a written report on a non-identifiable basis. It will not be possible for you to be identified personally. Only grouped responses will be presented in this report. All material collected will be kept confidential. No other person besides me and my supervisors, Professor Maralyn Foureur (and Joan Skinner when Maralyn Foureur is away) or the second supervisor, Jan Duke, will see the transcripts or MSR data. The thesis will be submitted for marking to the Graduate School of Nursing and Midwifery and deposited in the University Library. It is intended that one or more articles will be submitted for publication in scholarly journals or may be presented at national and international midwifery conferences. All audiotapes and transcripts and my notes will be destroyed two years after the end of the project.

If you have any questions or would like to receive further information about the project, please contact me at 463 6654 or my supervisors, Professors Maralyn Foureur or Jan Duke , at the Graduate School of Nursing and Midwifery at Victoria University, P O Box 600, Wellington, phone 472 1000.

Sue Lennox   Signed:

Appendix H: Mentored Midwives Consent Form

Mentored Midwives

CONSENT TO PARTICIPATION IN RESEARCH

Title of project: Study of Midwifery Mentorship

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may withdraw myself (or any information I have provided) from this project anytime before September 2006 without compromising my participation in the mentoring project.

I understand that any information I provide will be kept confidential to the researcher, the supervisors and the person who transcribes the tape recordings of our interviews, the published results will not use my name, and that no opinions will be attributed to me in any way that will identify me. I understand that the tape recording of interviews will be electronically wiped at the end of the project.

☐   I would like to receive a summary of the results of this

research when it is completed.

☐   I agree to take part in this research

signed:

name of participant

(please print clearly)

Date:

Appendix I: Mentor Information Sheet

MENTORS

Participant Information Sheet for a Study of Midwifery Mentorship

Researcher: Sue Lennox: Graduate School of Nursing and Midwifery, Victoria University of Wellington

Thank you for volunteering to participate in this research project which aims to explore the mentoring of 5 beginning midwives into their first year of independent midwifery practice by 4 experienced midwives. The main aim of the study will be to develop a model or framework for the mentoring of midwives in New Zealand. A second aim is to establish how to mentor midwives into safe, normal birth practices thereby fulfilling the midwifery mandate of "guardians of the normal.

As you know I am a PhD student in Midwifery at Victoria University of Wellington. As part of the degree I am undertaking this research project which will lead to a thesis. The University requires that ethics approval be obtained for research involving human participants.

This information sheet will set out clearly what data you will be asked to contribute to the research, prior to the start of the mentorship year, during the mentorship year and at the end of the mentorship year.

Mentorship will occur in two ways: during weekly group meetings between the 5 mentored midwives and the 4 mentors; through individual mentoring of each midwife as she identifies a need for consultation or in-person support. The mentorship is the subject not the object of the research. This means that you determine how the mentorship occurs. This is not set by me, the researcher. My research role is to describe how mentorship happens and to analyse and interpret what happens. In order to do that I am seeking your assistance in the following ways:

4. Undertake 4 interviews of one hour duration each;
   a. The first interview to take place between September/October 2005 to ask you to describe what are your expectations of the mentoring year (sample questions are attached);
   b. A second interview three months after the commencement of the mentorship year (April 2006) to ask you to describe how the experience of mentoring has been so far (sample questions are attached);

  c. A third interview six months after the commencement of the mentorship year (July2006) to ask you to reflect on how the mentoring year has been so far (sample questions are attached);

  d. A fourth and final interview at the completion of the mentorship year (September 2006) to ask you to reflect again on how the mentoring year was for you (sample questions are attached).

- The interviews will take place at a time and location that is mutually convenient to you and to me;

- You will be asked to choose a pseudonym for the interviews in order to assist in maintaining your anonymity.

- The interviews will be tape recorded and transcribed by a transcriber who will sign a confidentiality agreement not to reveal any of the contents.

- I will return the transcripts to you to check for accuracy of the comments you have made and ask you to amend any you feel are inaccurate.

- I will undertake a thematic analysis of the transcripts which will form part of my thesis.

- I may choose some of the comments made by you to illustrate the themes I develop however; you will not be identified in any of the material used.

- Only my supervisors Professor Maralyn Foureur (and Joan Skinner in her absence) and I will see the transcripts of the interviews. Since the transcripts will have pseudonyms attached, only I will know the true identity of the midwife mentor.

5. The weekly group meetings will be audiotaped and the tapes transcribed. I may undertake a thematic analysis of the transcripts and some comments may be used to illustrate those themes. I will also take notes after the meeting in order to monitor the content areas that are discussed during the meeting. No names will be used in the transcripts of these tape recordings or in my notes.

6. I will ask you to keep a log of the interactions you have with the mentored midwives (i.e. the mentorees). This will be in the form of a spreadsheet (attached) which will ask you to record telephone calls, when they occurred and what the content was; any in-person contact with the mentored midwife, when it occurred and the reason for the contact; weekly group meetings, time spent. This will enable me to undertake a costing analysis of the mentoring provided and will also add to the understanding of the changes in mentoring requests over the course of the mentorship year.

Should you feel the need to withdraw from the mentoring project, you may do so without question at any time before September 2006. Just let me know at the time.

All data collected will form the basis of my research project and will be put into a written report on a non-identifiable basis. It will not be possible for you to be identified personally. Only grouped responses will be presented in this report. All material collected will be kept confidential. No other person besides me and my supervisors, Professor Maralyn Foureur and Joan Skinner, will see the transcripts or MSR data. The thesis will be submitted for marking to the Graduate School of Nursing and Midwifery and deposited in the University Library. It is intended that one or more articles will be submitted for publication in scholarly journals or may be presented at national and international midwifery conferences. All audiotapes and

transcripts and my notes will be destroyed two years after the end of the project.

If you have any questions or would like to receive further information about the project, please contact me at 463 6654 or my supervisors, Professor Maralyn Foureur or Joan Skinner (in Professor Foureur's absence) or Administrative and second supervisor, Professor Jan Duke at the Graduate School of Nursing and Midwifery at Victoria University, P O Box 600, Wellington, phone 472 1000.

Sue Lennox   Signed:

Appendix J: Mentor Consent Form

MENTORS

CONSENT TO PARTICIPATION IN RESEARCH

Title of project: Study of Midwifery Mentorship

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may withdraw myself (or any information I have provided) from this project (before data collection and analysis is complete) without having to give reasons or without penalty of any sort.

I understand that any information I provide will be kept confidential to the researcher, the supervisors and the person who transcribes the tape recordings of our interview, the published results will not use my name, and that no opinions will be attributed to me in any way that will identify me. I understand that the tape recording of interviews will be electronically wiped at the end of the project unless I indicate that I would like them returned to me.

☐   I would like to receive a summary of the results of this research when it

is completed.

☐   I agree to take part in this research

signed:

name of participant

(please print clearly)   Date:

Appendix K: The Structured and Process of the Group Meetings

The meetings became a significant focus for the group over the mentoring year therefore a brief description of the structure and process is warranted. The meetings were held at the home of one of the participants; around her large kitchen table where experiences were shared over a cup of coffee or tea and nibbles. They were structured to enable the new graduates to bring whatever they wanted to the discussion group. This included stories from practice, questions and problems. All participants were involved in developing the meeting structure and supporting an evolving culture of trust within the group.

Each meeting was facilitated by a random volunteer from the mentoring group after social exchanges. The new graduate-mentor discussions were facilitated to follow a pre-determined structure. This included an initial exploration of issues, an identification of priorities by the new graduates, and a time quota for new graduate stories, questions or ideas allotted on the basis of their assessment of the importance of their issue. As the new graduates were the active partners in the mentoring group they initiated the stories of their experiences of practice each week. All members of the group responded to these stories, in order of seating around the table. The meeting process was structured to allow each new graduate uninterrupted time for talking and questioning. After each new graduate presented her story, one at a time, each group member, the mentors and the other new graduates, had uninterrupted time to respond to her story or ask clarifying questions. Sometimes reflective questions would be asked from the guidelines to reflective questions. This

format was followed by a summing up or response by the new graduate. If the subject could then be closed, the facilitator would ask the next new graduate to present and so on until each new graduate who had an issue or concern had presented.

Appendix L: Aggregated Birth Statistics: New Graduates and Comparators

This appendix describes the characteristics of women and modes of birth for women cared for by the new graduates during the study year with comparisons to all women giving birth in the local region.
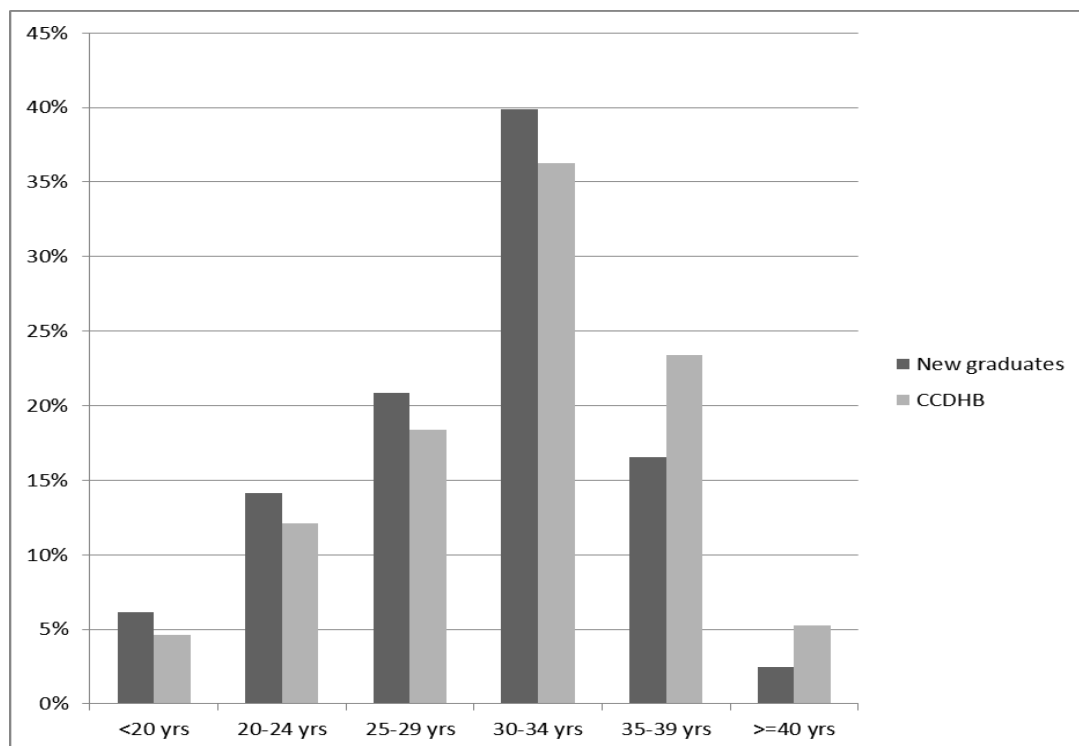

Figure 4 shows the age of the women cared for by the new graduates who were generally younger than all women giving birth in the local health district, Capital and Coast DHB (CCDHB) (average age 29.7 years compared to 31.2 years in the whole district).
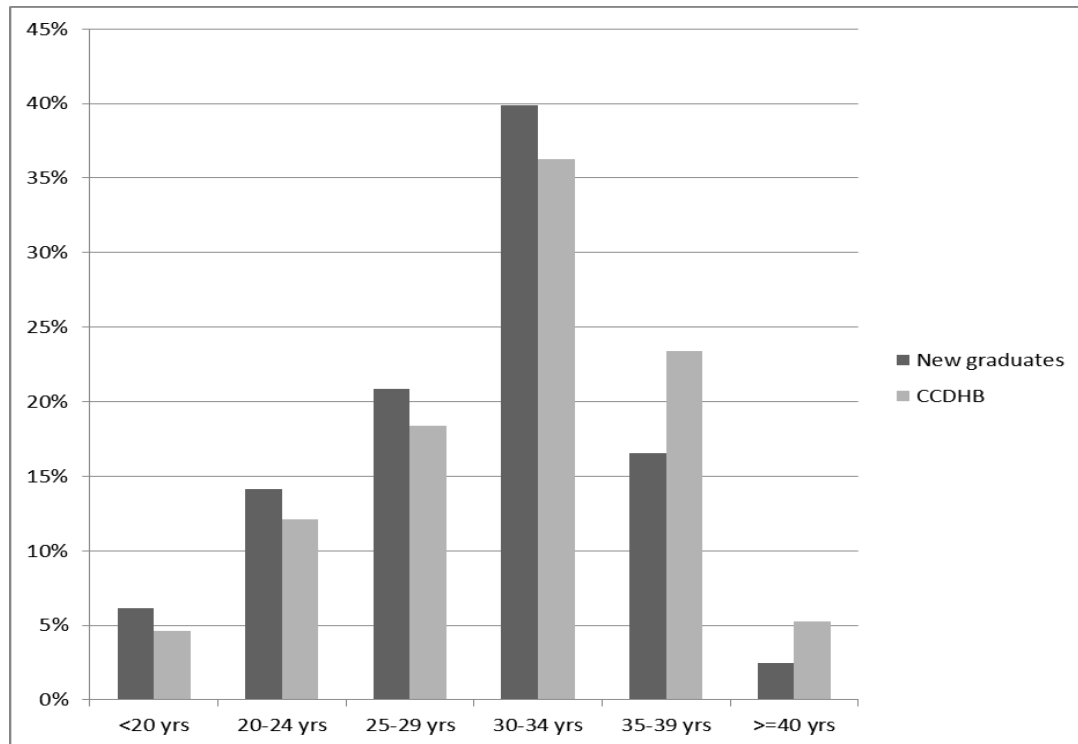
Figure 4: Age of women cared for in study population compared to age of women in local health district

The average age for women cared for by these new graduates was 29.7 years which was similar to the average age for all women booked by self-employed midwives at 30.6 years and for all women regardless of their LMC it was 31.4 years in the CCDHB (Fisher et al., 2008).

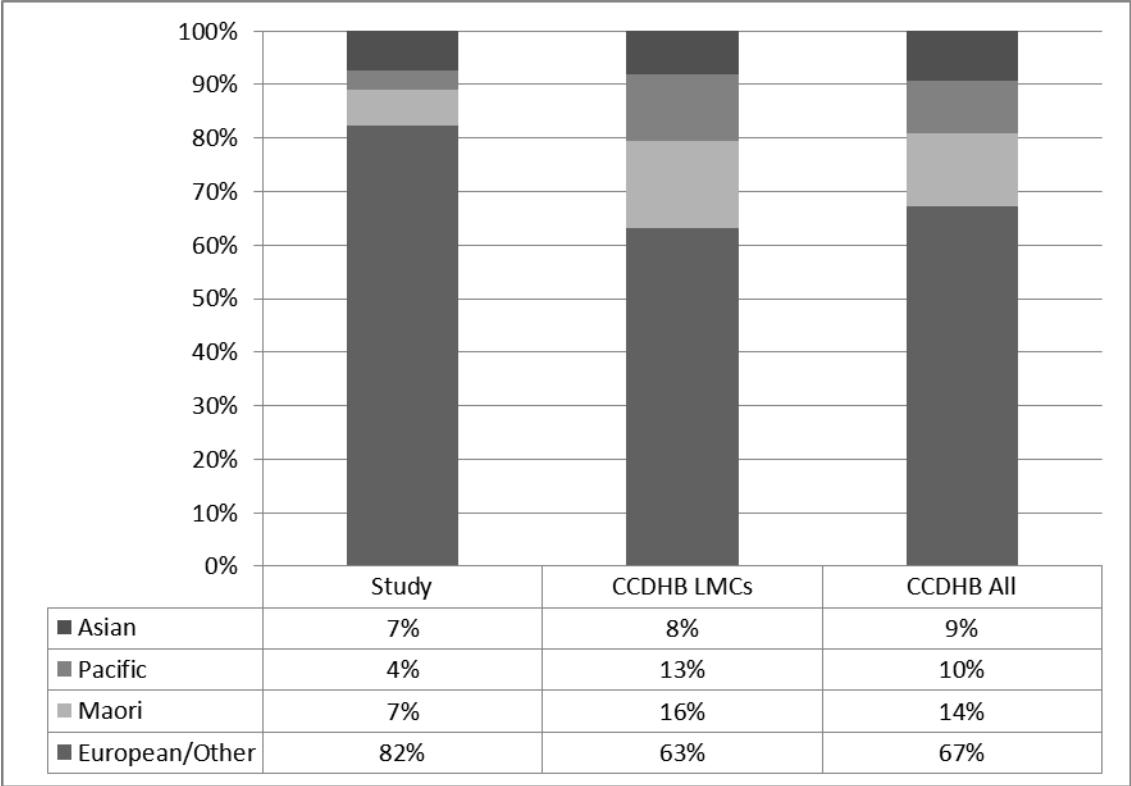|	Study	CCDHB LMCs	CCDHB All
■ Asian	7%	8%	9%
■ Pacific	4%	13%	10%
■ Maori	7%	16%	14%
■ European/Other	82%	63%	67%

Figure 5: Ethnicity of women cared for in study population compared to local health district

The new graduates in this study cared for a higher proportion of European/Other women and fewer Māori women than LMC midwives or in the whole population of women birthing at CCDHB.

The parity of the women is shown in Figure 5. 100 of the 163 women were primiparous (first birth) and 63 were multiparous (second or later birth). The new graduates had a higher proportion of primiparous women in their caseload (100 of the 163 women were first time mothers) compared to other self-employed midwives.

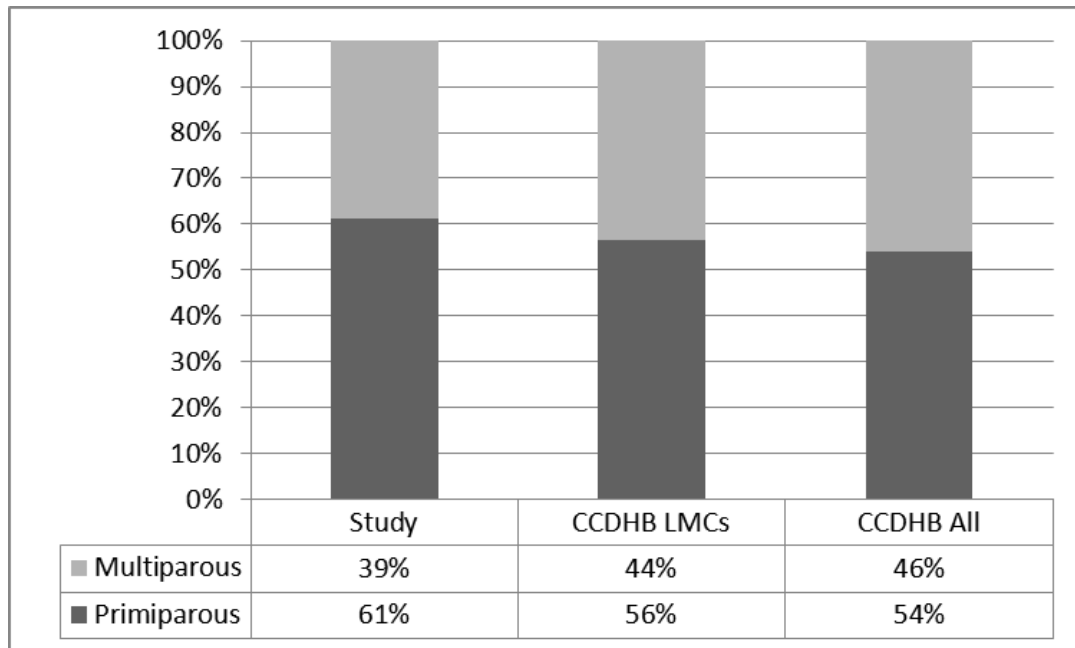|	Study	CCDHB LMCs	CCDHB All
■ Multiparous	39%	44%	46%
■ Primiparous	61%	56%	54%

Figure 6: Parity of women cared for in study population compared to local health district

The mode of birth for the women the new graduates cared for over the year is shown in

Figure 7. Two women experienced a vaginal breech birth and the rates of instrumental delivery and caesarean section are higher for primiparous women.
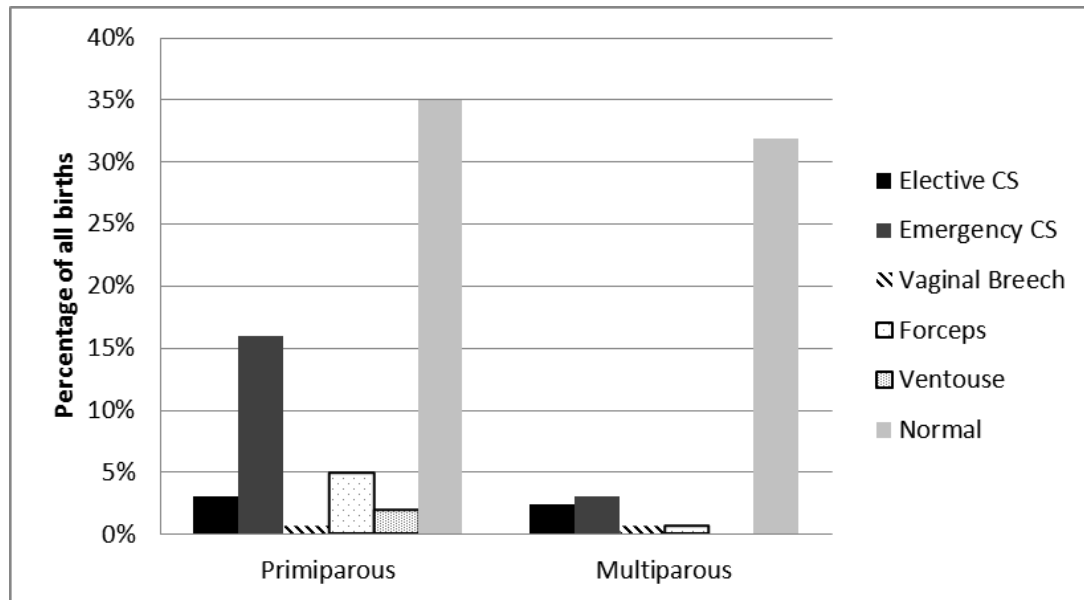
Figure 7: Parity and modes of birth for the 163 women cared for in study population

The women the new graduates cared for had similar rates of normal births (67%) and interventions (caesarean rates for both groups 25%) compared to women cared for by other self-employed midwives in this district (65%). This was despite having a higher percentage of first time and European mothers in their caseload which would generally skew the statistics because first times mothers commonly have more interventions than mothers who have previously delivered a baby. This reassurance is in line with the national statistics collected by MMPO about new graduate outcomes and reported in the New Zealand College of Midwives Journal (Dixon, 2010, p. 18).The ethnicity of the women cared for by the new graduates is shown in Figure 5 compared to all women giving birth in the local region (all births and also only those cared for by LMC midwives). The new graduates in the study had a higher proportion of European/Other women and fewer Māori than either other self-employed midwives or all midwives.

Figure 8 compares the modes of birth for women cared for by the new graduates with modes of birth for other women giving birth in the CCDHB area. The women the new graduates cared for had similar rates of normal births and interventions compared to women cared for by other self-employed midwives.

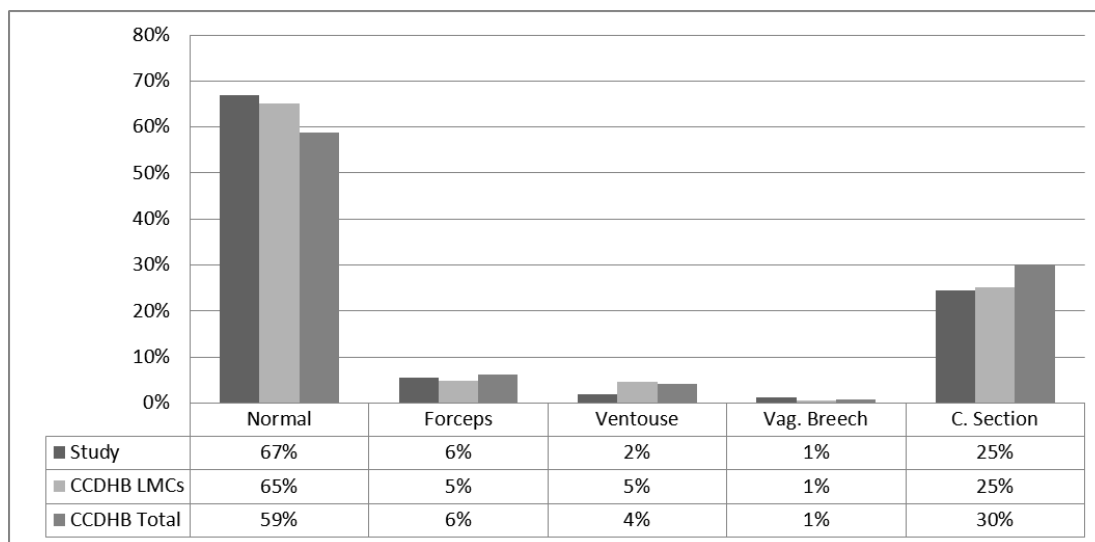|	Normal	Forceps	Ventouse	Vag. Breech	C. Section
■ Study	67%	6%	2%	1%	25%
■ CCDHB LMCs	65%	5%	5%	1%	25%
■ CCDHB Total	59%	6%	4%	1%	30%

Figure 8: Comparison of types of birth for study population compared to those for women cared for by LMCs and all women in local health district (Fisher, Hawley, Hardwick, & Maude, 2008)

REFERENCES

Anderson, L. M., & Pearson, C. M. (1999). The spiralling effect of uncivility in the workplace. *Academy of Management Review, 24*, 452-471.

Andrews, M., & Wallis, M. (1999). Mentorship in nursing: A literature review. *Journal of Advanced Nursing, 29*(1), 201-207.

Armitage, P., & Burnard, P. (1991). Mentors or preceptors? Narrowing the theory-practice gap. *Nurse Education Today, 11*, 225-229.

Asmar, C. (2007). Mentoring in the Graduate Certificate: Safety in numbers? *Synergy,* (26). Retrieved from

Ball, L., Curtis, P., & Kirkham, M. (2002). Why do midwives leave? (W. s. I. C. a. H. R. Group, Trans.). London: Royal College of Midwives.

Beecroft, P. C., Santner, S., Lacy, M. L., Kunzman, L., & Dorey, F. (2006). New graduate nurses' perceptions of mentoring: Six-year programme evaluation. *Journal of Advanced Nursing, 55*(6), 736-747.

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2009). Assessing new graduate nurse performance. *Nurse Educator, 34*(1), 17-22.

Berlew, D. E., & Douglas, T. (1966). The socialisation of managers: Effects of expectation of performance. *Administrative Science Quarterly, 11*(2), 207-223.

Berridge, E.-J., Sharpe, J., & Roberts, C. M. (2007). Bridging the gap: Supporting the transition from medical student to practising doctor-a two-weeek preparation programme after graduation. *Medical Teacher, 29*, 119-127.

Berry, L. E. (2011). Creating community: Strengthening education and practice participation through communities of practice. *International Journal of Nursing Education Scholarship, 8*(1).

Bishop, V. (2007). Literature review: Clinical supervision evaluation studies. In V. Bishop (Ed.), *Clinical supervision in practice: Some questions, answers and guidelines for professionals in health and social care*. Basingstoke: Palgrave Macmillan.

Bishop, V. (2008). Clinical governance and clinical supervision: Protecting standards of care. *Journal of research in nursing, 13*(3), 3-5.

Bowen, D. (1985). Were men meant to mentor women? *Training and Development Journal, 39*(1), 30-34.

Britten, N., Jones, R., Murphy, E., & Stacy, R. (1995). Qualitative research methods in general practice and primary care. *Family Practice, 12*(1), 104-114.

Buckley, S. J. (2009). *Gentle birth, gentle mothering*. Berkeley: Celestial Arts.

Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2000). Implications of an aging registered nurse workforce. *Journal of the American Medical Association, 283*(22), 2948-2954.

Butterworth, T. (1992). Clinical supervison as an emerging idea in nursing. In T. Butterworth & J. Faugier (Eds.), *Clinical supervision and mentoring in nursing* (pp. 3-17). London: Chapman and Hall.

Butterworth, T., Carson, J., Jeacock, J., & Clements, A. (1999). Stress, coping, burnout and job satisfaction in British nurses: Findings from the clinical supervision evaluation project. *Stress Medicine, 15*, 27-33.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303-311.

Chapman, H. R., & Kirby-Turner, N. (2002). Visual/verbal analogue scales: Examples of brief assessment methods to aid management of child and adult patients in clinical practice. *British Dental Journal, 193*(8), 447-450.

Chiles, T. A. (2006). *Constructing professional identity: Discourse and mentoring in the workplace* Doctor of Philosophy PhD, Victoria University of Wellington, Wellington.

Chiles, T. A. (2007). The construction of an identity as 'mentor' in white collar and academic workplaces: A preliminary analysis. *Journal of Pragmatics, 39*(4).

Chinn, P. L., & Kramer, M. K. (2008). *Integrated theory and knowledge development in nursing* (7th ed.). St. Louis: Mosby Elsevier.

Clark, K. H. (2004). *Matchmaking: A study of the benefits, barriers and other factors affecting mentoring relationships and mentoring programmes in New Zealand libraries and information centres.* Masters, Victoria University of Wellington, Wellington.

Clarke, S. P., & Aiken, L. H. (2003). Failure to Rescue. *American Journal of Nursing, 103*(1), 42-47.

Clutterbuck, D. (2004). *Everyone needs a mentor* (3rd ed.). London: Chartered Institute of Personnel and Development.

Clutterbuck, D. (2009). *Everyone needs a mentor* (4th ed.). London: Chartered Institute of Personnel and Development.

Collins. (1990). The new Collins Dictionary and Thesaurus in one volume. In W. T. MeLeod (Ed.), *The new Collins Dictionary and Thesaurus in one volume* (Vol. One). London & Glasgow: Collins.

Collins, E. G. C., & Scott, P. (1978). Everyone who makes it has a mentor. *Harvard Business Review, 56*(4), 89-101.

Colliver, J. A. (2002). Constructivism: The view of knowledge that ended philosophy or a theory of learning and instruction. *Teaching and learning in medicine, 14*(1), 49-51.

Crabtree, S. (2004). Midwives constructing 'normal birth'. In S. Downe (Ed.), *Normal childbirth evidence and debate*. Edinburgh: Churchill Livingstone.

Cresswell, J. W., Shope, R., Plano, V. L., & Green, D. O. (2006). How interpretative qualitative research extends mixed method research. *Research in School, 13*(1), 1-11.

Curtis, P., Ball, L., & Kirkham, M. (2006a). Research and education. Ceasing to practise midwifery: working life and employment choices. *British Journal of Midwifery, 14*(6), 336-338.

Curtis, P., Ball, L., & Kirkham, M. (2006b). Why do midwives leave? (Not) being the kind of midwife you want to be: Sheffield Hallam University Research Archive.

Daloz, L. A. (1986). *Effective teaching and mentoring: Realizing the transformational power of adult learning experiences*. San Fransisco: Jossey-Bass Publishers.

Dalton, G. W., Thompson, P. H., & Price, R. L. (1977). The four stages of professional careers: A new look at performance by professionals. *Organizational Dynamics, 6*(1), 19-42.

Darwin, A., & Palmer, E. (2010). Mentoring circles in higher education. *Higher Education Research & Development, 28*(2), 125-136.

Davis, D., Foureur, M., Clements, V., Brodie, P., & Herbison, P. (2011). The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women and Birth, 24*(3), *(in press)*.

Deery, R. (2005). An action-research study exploring midwives' support needs and the effect of group clinical supervision.. *Midwifery, 21*(2), 161-176.

Deery, R., & Corby, D. (1996). A case for clinical supervision in midwifery. In M. Kirkham (Ed.), *Supervision of Midwives*. Cheshire: Books for Midwives.

Deery, R., & Kirkham, M. (2006). Supporting midwives to support women. In L. Page & R. McCandlish (Eds.), *The New Midwifery: Science and Sensitivity in Practice*. London Elsevier.

Del Bueno, D. J. (2005). A crisis in critical thinking. *Nursing Education Perspectives, 26*(5), 278-282.

District Health Boards New Zealand. (2006). Midwifery Workforce Strategy (pp. 48). Wellington: DHBNZ.

Dreher, G. F., & Ash, R. A. (1990). A comparative study of mentoirng among men and women in managerial, professional, and technical positions. *Journal of Applied Psychology, 75*(5), 539-546.

Duchscher, J. E. B. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing, 39*(10), 441-450.

Duchscher, J. E. B. (2009). Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113.

Eby, L. T. (1997). Alternative forms of mentoring in changing organizational environments: A conceptual extension of the mentoring literature. *Journal of Vocational Behavior, 51*(1), 125-144.

Edwards, N., & MacDonald, J.-A. (2009). Building nurses' capacity in community health services. *Int J Nurs Educ Scholarsh, 6*(1), Article25.

Engel, C. (2000). *Towards a sustainable model of midiwfery practice in a continuity of care setting*. A thesis submitted to the Victoria University of Wellington for the requirements for degree of Master of Arts in Midwifery. Wellington.

Espel, E. C., Blackburn, E. H., Lin, J., Dhabhar, F. S., Adler, N. E., Morrow, J. D., & Cawthon, R. M. (2009). Accelerated telonomes shortening in response to life stress. *Proceedings of the National Academy of Sciences of the United States of America, 101*(49), 17312-17315.

Falcione, N., Falcione, P., & Sanchez, C. (1994). Critical thinking disposition as a measure of competent clinical judgement: The development of the California Critical Thinking Disposition Inventory. *Journal of Nursing Education, 33*(8), 345-350.

Finnerty, G. P., R, Graham, L & Magnusson, C:. (2005). Do we value our midwife mentors? *MIDIRS Midiwfery Digest 15*(2).

Firtko, A., Stewart, R., & Knox, N. (2005). Understanding mentoring and preceptorship:Clarifying the quagmire. *Contemporary Nurse, 19*(1-2), 32-40.

Fisher, K., Hawley, J., Hardwick, A., & Maude, R. (2008). The Women's Health Service Annual Clinical Report 2006. Wellington: Women's Health Service, Capital and Coast District Health Board 2008.

Foureur, M. (2008). Creating birth space to enable undisturbed birth. In K. Fahy, M. Foureur & C. Hastie (Eds.), *Birth territory and midwifery guardianship Theory for practice, education and research*. Edinburgh: Butterworth Heinemann.

Gould, D., Kelly, D., Goldstone, L., & Gammon, J. (2001). Examining the validity of pressure ulcer risk assessment scales: Developing and using illustrated patient simulations to collect data. *Journal of Clinical Nursing, 10*(5), 697-706.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco, CA: Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Education Communication and Technology Journal, 30*(4), 233-252.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.

Guilliland, K. (1996). National Newsletter. Christchurch: New Zealand College of Midwives.

Guilliland, K. (1998). The New Zealand Midwifery Mentor Partnership. In C. Vance, Olson, R. (Ed.), *The Mentor Connection in Nursing*. New York: Springer Publishing.

Guilliland, K., & Pairman, S. (1995). *The Midwifery Partnership: A model for practice*. Wellington: Victoria University of Wellington.

Guilliland, K., & Pairman, S. (2010). *The midwifery partnership: A model for practice* (2nd ed.). Christchurch: New Zealand College of Midwives.

Hall, L. (1998). Mentoring relationships of New Zealand nurses: Results of an empirical study (part 2). *Collegian, 5*(1), 32-35.

Hammersley, M. (1992). *What's wrong with ethnography?* London: Routledge.

Harris, S. R. (2003). Studying equality/inequality: Naturalistic and constructivist approaches to equality in marriage. *Journal of Contemporary Ethnography, 32*(2), 200-232.

Hart, E., & Bond, M. (1999). *Action Research for Health and Social Care*. Buckingham, Philadelphia: Open University Press.

Harvey, G., Loftus-Hills, A., Rycroft-Malone, J., Titchen, A., Kitson, A., & McCormack, B. S., K. (2002). Getting evidence into practice: the role and function of facilitators. *Journal of Advanced Nursing, 37*(6), 577-588.

Hays, T., Gerber, R., & Minichiello, V. (1999). Mentorship: A review of the concept. *UNICORN, 25*(2), 84-95.

The Health and Disability Commissioner Act 1994, 88 (1996 07/07/2010).

Health Practitioners Competency Assurance Act 2003 Pub. L. No. 10 August 2008 (2003 18th September 2003).

Higgins, M. C., & Kram, K. E. (2001). Reconceptualising mentoring at work: A developmental network perspective. *The Academy of Management Review, 26*(2), 264-289.

Hobbs, J., & Green, S. (2003). Development of a preceptorship programme. *British Journal of Midwifery, 11*(6), 372-375.

Holland, D. (2001). Practice wisdom: Mentoring-a personal analysis. [opinion piece]. *New Zealand College of Midwives Journal*(23), 15-18.

Homer. (1945). The Odyssey (E. V. Rieu, Trans.). Middlesex: Penguin Books.

Homer, C., Brodie, P., Leap, N. (2008). *Midwifery Continuity of Care A Practical Guide*. Sydney: Churchill Livingston, Elsevier.

Howe, K. R. (2004). A critique of Experimentalism. *Qualitative Inquiry, 10*(1), 42-61.

Hrykas, K. (2001). The effects of clinical supervision on the quality of care: examining the results of team supervision. *Journal of Advanced Nursing, 33*(4), 492-502.

Humpel, N., & Caputi, P. (2001). Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses. *Journal of Psychiatirc and Mental Health Nursing, 8*, 399-403.

Jevitt, C. M., & Beckstead, J. W. (2004). Retirement among Florida's certified Nurse-Midwives: An impending workforce crisis. *Journal of Midwifery & Women's Health, 49*(1), 39-46.

Johns, C., & Freshwater, D. (Eds.). (1998). *Transforming nursing through reflective practice* (Vol. 13). Osney Mead, Oxford ; Malden, MA: Blackwell Science.

Johnson, P. (2007). Retaining and advancing librarians of color. *College & Research Libraries, 68*(5), 405-417.

Kensington, M. (2005). *Mentoring in New Zealand: The liminal journey the midwife makes in transition to an independent autonomous practitioner.* Master of Public Health MA, University of Otago, Dunedin.

Kensington, M. (2006). The faces of mentoring in New Zealand: Realities for the new graduate midwife. *New Zealand College of Midwives Journal, 35*, 22-27.

Kirkham, M. (1999). The culture of midwifery in the national health service in England. *Journal of Advanced Nursing, 30*(3), 732-739.

Kirkham, M. (Ed.). (1996). *Supervision of Midwives* Cheshire: Books for Midwives.

Kirkham, M., & Morgan, R. (2006 (a)). Why midwives return and their subsequent experience. *Women's Informed Childbearing and Health Research Group* Retrieved 4/4/2009, 2009

Kirkham, M., Morgan, R., & Davies, C. (2006). Why midwives stay. *Women's Informed Childbearing and Health Research Group* Retrieved 4/4/2009, 2009

Kirkham, M., & Stapleton, H. (2000). Midwives' support needs as childbirth changes. *Journal of Advanced Nursing, 32*, 465-472.

Klein, M. C. (2010). What do episiotomy and cesarean have to do with Copernicus, Galileo, and Newton? *Birth: Issues in Perinatal Care, 37*(1), 1-2. doi: 10.1111/j.1523-536X.2009.00371.x

Knowles, M. (1973). *The Adult Learner: A Neglected Species.*: Gulf Publishing Company, P.O. Box 2608, Houston, TX 77001 ($7.95).

Knowles, M. (1980). *The modern practice of adult education: From pedagogy to androgogy* (Revised and updated ed.). New Jersey: Cambridge Adult Education.

Kram, K. E. (1980). *Mentoring processes at work: Developmental relationships in managerial careers.* PhD, Yale University, New Haven.

Kram, K. E. (1983). Phases of the Mentor Relationship. [Research]. *The Academy of Management, 26*, pp608-605.

Kram, K. E. (1985). Mentoring at work: Developmental relationships in organizational Life. *Administrative Science Quarterly, Vol. 30*(No. 3), pp. 454-456.

Kram, K. E. (1988). *Mentoring at work: Developmental relationships in organizational life*. Lanham,New York, London: University Press of America.

Kram, K. E., & Isabella, L. A. (1985). Mentoring alternatives: The role of peer relationships in career development. *Academy of Management Journal, 28*(1), 110-133.

Kramer, M. (1974). *Reality shock:Why nurses leave nursing*. St. Louis, MO: C.V.Mosby.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago: Chicargo University Press.

Leap, N. (1997). Making sense of 'horizontal violence' in midwifery. *British Journal of Midwifery, 5*(11).

Lee, S., & Mackenzie, L. (2003). Starting out in rural new south wales: The experience of new graduate occupational therapists. *Australian Journal of Rural Health, 11*, 36-43.

Lennox, S. M. (2003). *Honouring the sacred in childbirth: A midwife's stories of women's developing sense of self.* M.A. (Applied) in Midwifery, Victoria University of Wellington, Wellington.

Lennox, S. M. (2005). *Meeting Log Book*. Research Documentation. (1). Wellington.

Lennox, S. M. (2006). *Interviews: Notes and participant checks.* Wellington.

Lennox, S. M., Skinner, J., & Foureur, M. (2008). Mentorship, preceptorship and clinical supervision: Three key processes for supporting midwives. *New Zealand College of Midwives Journal*(39), 7-12.

Levinson, D., Darrow, C., Klein, E., Levinson, M., & McKee, B. (1978). *The seasons of a man's life*. New York: Ballantine Books.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Long, J. (1997). The dark side of mentoring. *Australian Educational Researcher, 24*(2), 115-133.

Macdonald, N. (2004, 03/08/2004). Breech baby died during delivery, *The Dominion Post*.

Mace, W. (2010, 15/04/2010). Kiwis worse in the world for bullying, *The Dominion Post*.

Mackin, P., & Sinclair, M. (1998). Labour ward midwives' perception of stress. *Journal of Advanced Nursing, 27*, 986-991.

Managh, C., Macdonald, N., & Andrew, K. (2004, 12/11/2004). Midwives under scrutiny. Second homebirth death, Newspaper article, *The Dominion Post,* p. A1.

McIver, F. (2002). *Providing care under stress: Creating risk 12 midwives experience of horizontal violence and the effects on the provison of midwifery care.* Master of Arts in Midwifery, Massey University, Palmerston North.

McKenna, B., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96.

McKenna, L. (2003). Nurturing the future of midwifery through mentoring. *Aust J Midwifery, 16*(2), 7-10.

McLardy, E. (2003). *On-call 24/7 midwives negotiate home and work boundaries*. A thesis submitted to the Victoria University of Wellington in partial fulfilment of the requirements for the degree of Master of Arts (Applied) in Midwifery. Wellington.

McPherson, L., & Barnett, M. (2006). Beginning practice in child protection: A blended learning approach. *Social Work Education, 25*(2), 192-198.

McVeigh, H., Ford, K., O'Donnell, A., Rushby, C., & Squance, J. (2009). A framework for mentor support in community-based placements. *Nursing Standard, 23*(45), 35-41.

Midwifery Council of New Zealand. (2005). Midpoint. In S. Pairman (Ed.), *Midwifery Council of New Zealand Newsletter* (Vol. October 2005). Wellington: Midwifery Council of New Zealand.

Midwifery Council of New Zealand. (2007). Midwifery Competence Retrieved 15/06/2011, 2011

Midwifery Council of New Zealand. (2010). *Midwifery Scope of Practice*. Wellington: Government Gazette.

Midwives, I. C. o. (2005). Definition of the midwife Retrieved 08/06/2011, 2011, from http://www.internationalmidwives.org

Miller, S. (2002). How safe is a tired midwife? *New Zealand College of Midiwves Journal, 27*, 5-8.

Mills, J., Francis, K., Bonner, A. (2008). Walking with another: rural nurses'
      experiences of mentoring. *Journal of research in nursing, 13*(23), 23-35.

Milner, T., & Bossers, A. (2004). Evaluation of the mentor-mentee relationship in an
      occupational therapy mentorship programme. *Occupational Therapy
      International, 11*(2), 96-111.

Ministry of Health. (1996). *Notice pursuant to Section 51 of the Health and
      Disability Services Act 1993 concerning the provision of maternity services*.
      Wellington: Ministry of Health.

Ministry of Health. (1999). *Maternity Consumer Satisfaction Survey*. Wellington.

Ministry of Health. (2002). *Maternity Services Notice*   Wellington: Retrieved from
      http://www.moh.govt.nz/moh.nsf/pagesmh/1098/$File/final-section88-
      maternity-notice-april-2002.pdf.

Ministry of Health. (2007a). Clinical Training Agency Purshasing Intentions
      2007/2008 Retrieved 18/10/07, 2007

Ministry of Health. (2007b). *Maternity Services Notice*. (41). New Zealand Gazette:
      Retrieved from http://www.moh.govt.nz/moh.nsf/pagesmh/5845/$File/s88-
      primary-maternity-services-notice-gazetted-2007.pdf.

Ministry, o. H. (2009). *Midwifery First Year of Practice Programme Interim
      Specification* Wellington: Ministry of Health.

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological
      implications of combining qualitative and quantative methods. *Journal of
      Mixed Methods Research, 1*(1), 48-76.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification
      strategies for establishing reliability and validity in qualitative research.
      International Journal of Qualitative Methods, 1(2), 1-19.

Morton-Cooper, A., & Palmer, A. (2005(b)). *Mentoring, preceptoring and clinical
      supervsion* (2nd Edition 4th Reprint ed.). Oxford: Blackwell Science Ltd.

Namie, G. (2010). Stress, telomeres, new clinical tests & the real world. *2010*(9th
      July), http://www.workplacebullying.org/2010/2007/2007/telomeres/#more-
      2744. Retrieved from

Needham, A. W. (2003). *Workplace bullying: The costly business secret*. Auckland:
      Penguin.

New Zealand College of Midwives. (1996). *NZCOM Consensus statement:
      Mentoring*, Christchurch.

New Zealand College of Midwives. (2000). NZCOM Consensus Statement:
      Mentoring *Consensus Statements*.
      http://www.midwife.org.nz/index.cfm/3,108,559/mentoring-2000.pdf: New
      Zealand College of Midwives.

New Zealand College of Midwives. (2005). Midwives Handbook for Practice. Christchurch: New Zealand College of Midwives.

New Zealand College of Midwives. (2007). The Midwifery First Year of Practice Programme. *2008*(11/04/08). Retrieved from doi:http://www.midwife.org.nz/index.cfm/1,171,html

Newton, J. M., & McKenna, L. (2007). The transitional journey through the graduate year: A focus group study. *International Journal of Nursing Studies, 44*, 1231-1237.

Nurses Amendment Act 1990 (1990).

Oliver, P. (2008). Midwifery First Year of Practice Pilot Programme Evaluation-Final Report July 2008. Christchurch: Clinical Training Agency, Health and Disabilities National Service Directorate, Ministry of Health.

Pairman, S. (1998a). *The midwifery partnership: An exploration of the midwife/woman relationship.* Master of Midwifery, Victoria University of Wellington, Wellington.

Pairman, S. (1998b). Women-centred midwifery: Partnerships or professional friendships? *New Zealand College of Midwives Journal*(19), 5-10.

Pairman, S. (1999). Partnership revisited: Towards midwifery theory. *New Zealand College of Midwives Journal, 21*.

Pairman, S. (2006). From autonomy and back again: Educating midwives across a century Part 2. *New Zealand College of Midwives Journal, 34*, 11-15.

Pairman, S. (2008, July 2008). Chairperson's column. *Midpoint* Retrieved 10th October, 2008, 2008

Passant, L. (2002). *Transitioning from student midwife into midwife: the experience of a group of newly graduated midwives working in an innovative model of midwifery care.* Masters of Midwifery MA Midwifery, UTS, Sydney.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. California: Sage Publications Inc.

Pegg, M. (1999). The art of mentoring. *Industrial and commercial training, 31*(4), 136.

Pilobolus. (2010). Symbiosis Retrieved March 22, 2011, from http://www.ted.com/talks/pilobolus_perform_symbiosis.html

Powell-Kennedy, H., Erickson-Owens, D., & Davis, J. P. (2006). Voices of diversity in midwifery: A qualitative research study. *Journal of Midwifery and Women's Health, 51*(2), 85-90.

Proctor, B. (2006). *Group supervision: A guide to creative practice*. London: Sage Publications Ltd.

Proulx, D. M., & Bourcier, B. J. (2008). Graduate Nurses in the intensive care unit: An orientation model. *Critical Care Nurse, 28*(4), 44-52.

Rafferty, A. M., Allcock, N., & Lathlean, J. (1996). The theory/practice 'gap': Taking issue with the issue. *Journal of Advanced Nursing, 23*(4), 685-691.

Raumati Hook, G., Waaka, T., & Raumati, L. P. (2007). Mentoring Maori within a Pakeha framework. *MAI Review, 3*(Target Article 1).

Reardon, M., & Ferrall, S. (2006). Revitalizing an approach to supporting new graduates: Building confidence and comfort. *Oncology Nursing Forum, 33*(2).

Rhéaume, A., Clément, L., & LeBel, N. (2011). Understanding intention to leave amongst new graduate Canadian nurses: A repeated cross sectional survey. *International Journal of Nursing, 48*(4), 490-400.

Ritchie, A. (1999). *Group mentoring and the professional socialisation of graduate librarians: A programme evaluation.* Masters by Research Masters, Curtin University of Technology, Perth.

Ritchie, A., & Genoni, P. (2002). Group mentoring and professionalism: A group evaluation. *Library Management, 23*(1/2).

Roche, G. R. (1979). Much ado about mentors.. *Harvard Business Review, 57*(1), 17-28.

Rochester, S., Kilstoff, K., & Scott, G. (2005). Learning from success: Improving undergraduate education through understanding the capabilities of successful nurse graduates. *Nurse Education Today, 25*(3), 181-189.

Rodgers, B. I. (1989). Concepts, analysis and the development of a nursing knowledge: the evolutionary cycle. *Journal of Advanced Nursing, 14*(4), 330-335.

Rogers, L. (1968). Interpersonal Relationships: USA 2000. *Journal of Applied Behavioral Science, 4*(3), 265-280.

Rubin, H., & Rubin, I. (1995). *Qualitative Interviewing: The art of hearing data.* Thousand Oaks, California: Sage Publications.

Sandall, J. (1997). Midwifery, burnout and continuity of care. *British Journal of Midiwfery, 2*, 106-111.

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in nursing and health*(23), 334-340.

Sandelowski, M. (2003). Tables or Tableaux? The challenges of writing and reading mixed methods studies. In A. Tashakkori, Teddlie, C. (Ed.), *Handbook of mixed methods in social and behavioural research*. Thousand Oaks, London, New Delhi: Sage Publications, Inc.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in nursing and health, 33*(1), 77-84.

Sandelowski, M., & Barroso, J. (2003). Writing the proposal for a qualitative research methodology project. *Qualitative Health Research, 13*(6), 781-820.

Schott, J. (1996). The needs of midwives: Managing stress and change. In D. Kroll (Ed.), *Midwifery care of the future*. London: Bailliere Tindall.

Scott, E. S., & Smith, S. D. (2008). Group mentoring: A transition-to-work strategy. *Journal for Nurses in Staff Development, 24*(5), 232-238.

Scott, G., & Yates, W. (2002). Using successful graduates to improve the quality of undergraduate engineering programmes. *European Journal of Engineering Education, 27*(4), 363-378.

Severinsson, E., Haruna, M., & Friberg, F. (2010). Midwives' group supervision and the influence of their continuity of care model – a pilot study. *Journal of Nursing Management, 18*(4), 400-408. doi: 10.1111/j.1365-2834.2010.01106.x

Shapiro, E. C., Haseltine, F. P., & Rowe, M. P. (1978). Moving up: Role models, mentors, and the "patron system". *Sloan Management Review, 19*(3), 51-58.

Shaw, K. B., Mist, S., Dixon, M. W., Goldby, M., Weih, J., Bauer, V. K., & Ritenbaugh, C. (2003). The Oregon Center for Complementary and Alternative Medicine career development program: Innovation in research training for complementary and alternative medicine. *Teaching and learning in medicine, 15*(1), 45-51.

Singleton, R. C. (1993). *Mentorship and professional socialization in a theological seminary setting.* PhD, The University of Texas at Austin, Austin.

Smith, E. R., Basmasjian, K. G., Kirell, L., & Koziol, S. (2003). On learning to teach English teachers: A textual protrait of mentoring. *English Education, 36*(1), 6-34.

Smythe, E. (1998). *'Being safe in childbirth': A hermeneutic interpretation of the narratives of women and practitioners.* PhD, Massey University, Palmerston North.

Sorensen, H. A. J., & Yankech, L. R. (2008). Precepting in the fast lane: Improving critical thinking in new graduate nurses. *The Journal of Education in Nursing, 39*(5), 208-215.

Stapleton, H., Duerden, J., & Kirkham, M. (1998). Evaluation of the impactof the supervision of midwives on professional practice and the quality of midwifery care. London: English National Board for Nursing, Midwifery and Health Visiting.

Steenbergen, K., Mackenzie, L. (2004). Professional support in rural New South Wales: Perceptions of new graduate occupational therapists. *Australian Journal of Rural Health, 12*, 160-163.

Stewart, B. M., & Kreuger, L. E. (1996). An evolutionary concept analysis of mentoring in nursing. *Journal of professional nursing, 12*(5), 311-321.

Stewart, D. (2000). *Tomorrow's principals today*. Palmerston North: Massey University, Kanuka Grove Press.

Stewart, D. (2008, 20/09/2009). [Collaborative critique based on evidence of practice: The Ariki Project].

Stewart, S., & Wootton, R. (2005b). Mentoring and New Zealand midwives: a survey of mentoring practice amongst registered midwives who are members of the New Zealand College of Midwives (pp. 1-55). Brisbane: Centre for Online Health, University of Queensland, Brisbane

Surtees, R. (2003). *Midwifery as feminist praxis in Aotearoa/ New Zealand*. A Thesis submitted for a Doctor of Philosophy in Education, University of Cantebury. Christchurch.

Surtees, R. (2008). 'Inductions of labour': on becoming an experienced midwifery practitioner in Aotearoa/New Zealand. *Nursing Inquiry, 15*(March), 11-20.

Tashakkori, A., Teddlie, C. (2003a). Tha past and future of mixed methods research from data triangulation to mixed model designs. In A. Tashakkori, Teddlie, C. (Ed.), *Handbook of mixed methods in social & behavioral research*. London, Thousand Oaks & New Delhi: Sage Publications.

Tashakkori, A., Teddlie, C. (Ed.). (2003b). *Handbook of mixed methods in social & behavioral research*. London, Thousand Oaks & New Delhi: Sage Publications.

Taylor, M. (1996). An ex-midwife's reflections on supervision from a psychotherapeutic viewpoint In M. Kirkham (Ed.), *Supervison of midwives* (pp. 213-222). Hale: Books for Midwives.

Theobald, K. (2002). Mentoring: Improving transition to practice. *Australian Journal of Advanced Nursing, 20*(1), 27-33.

Ulrich, B., Krozek, C., Early, S., Ashlock, C., Maquez Africa, L., & Carman, M. (2010). Improving retention, confidence, and competence of new graduate nurss: Results from a 10-year longitudinal database. *Nursing Economics, 28*(6), 363-376.

Vance, C. (1977). *A group profile of contemporary influentials in American Nursing leadership.* PhD PhD, Columbia University, Columbia.

Vance, C. (1982). The mentor connection. *Journal of Nursing Administration, 12*(4), 7-13.

Wakelin, K. (2006). *Staying or leaving: a telephone survey of midwives exploring the sustainability of their practice as lead maternity carers in one urban region of New Zealand* MA(Applied) in Midwifery MA (Applied) in Midwifery, Victoria University of Wellington, Wellington.

Watson, N. (1999). Mentoring today-The student's views. An investigative study of pre-registration nursing students' expereinces and perceptions of mentoring in one theory/practice module of the Common Foundation Programme on a Project 2000 course. *Journal of Advanced Nursing, 29*(1), 245-262.

Whitbeck, C. (2001). Group mentoring to foster the responsible conduct of research. *Science and Engineering Ethics, 7*(4), 541-558.

White, E., Butterworth, T., Bishop, V., Carson, J., Jeacock, J., & Clements, A. (1998). Clinical supervision. *Journal of Advanced Nursing, 28*(1), 185-192.

Wilson, H. J. D. (1999). *Supervision and the culture of general practice.* Master of General Practice Master of General Practice, Otago University, Dunedin.

Winstanley, J. (2000a). Manchester clinical supervision scale. *Nursing Standard, 14*(19), 31/32.

Winstanley, J. (2000b). *The Manchester Clinical Supervision Scale*. Manchester: University of Manchester.

Wrightson, J. (2001). Multidisciplinary mentorship in practice. *Practising Midwife, 4*(9), 19-21.

Yalom, I. D. (1975). *The theory and practice of group psychotherapy* (2nd ed.). New York: Basic Books, Inc.

Yoder, L. H. (1990). Mentoring: A concept analysis. *Nursing Administration Quarterly, 15*(1), 9-19.

Yoder, L. H. (1995). Staff Nurses' career development relationships and self-reports of professionalism, job satisfaction and intent to stay. *Nursing Research, 44*(5), 290-297.

Zachary, L. (2010). Group Mentoring. *Human Resources Newsletter*. Retrieved from http://humanresources.about.com/od/coachingmentoring/a/group_mentoring.htm