THE TRANSITION TO PRACTICE FOR NEW REGISTRANT MIDWIVES

BUILDING, BRIDGING, BEING:
THE TRANSITION TO CLINICAL PRACTICE FOR NEW REGISTRANT MIDWIVES IN ONTARIO

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A Thesis submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Master of Science

McMaster University MASTER OF SCIENCE (2018) Hamilton, Ontario (Health Science Education)

TITLE: Building, Bridging, Being: The Transition to Clinical Practice for New Registrant Midwives in Ontario AUTHOR: Christine Sandor, B.Sc. (McMaster University) B.H.Sc. (McMaster University) SUPERVISOR: Dr. Beth Murray Davis NUMBER OF PAGES: xiv, 153

Lay Abstract

The transition to clinical practice is a phenomenon that all health care professionals experience and one that has been studied in many fields of health care, yet remains largely unexamined for Canadian midwives. This study asked the question: *How do new registrant midwives in Ontario navigate the transition from student to clinician during their first year of clinical practice?* Thirteen interviews were conducted with Ontario midwives from three participant groups: A) New registrants in their first year of clinical practice; B) Registered midwives with 1-5 years of clinical experience; C) Registered midwives who work with new registrants as supervisors or mentors. The findings of this study led to the development of the Building, Bridging, and Being theory, which helps explain how midwives in Ontario transition to clinical practice and provides a starting point for further research centered around the transition to clinical practice midwives in Ontario and throughout Canada.

Abstract

Background: The transition to clinical practice is a phenomenon that all health care professionals experience and one that has been studied in many fields of health care, yet remains largely unexamined for Canadian midwives. This study asked the question: *How do new registrant midwives in Ontario navigate the transition from student to clinician during their first year of clinical practice?*

Methodology: In this grounded theory study, a total of 13 semi-structured interviews were conducted with Ontario midwives from three participant groups: A) New registrants in their first year of clinical practice; B) Registered midwives with 1-5 years of clinical experience; C) Registered midwives who work with new registrants as supervisors or mentors.

Findings: The Building, Bridging, and Being theory describes how new registrants transitioned to clinical practice. During the Building phase, individuals developed the knowledge and skills for clinical practice; midwifery students experienced elements of this phase during their final clinical placement. The Bridging phase occurred when new registrants embarked on independent clinical practice; this phase was characterized by providing clinical care without the safety net of a preceptor. Finally, the Being phase occurred when new registrants developed confidence in their skills and professional identity as midwives. A final theme, Bettering, encompassed participants' suggestions of ways to help improve the transition process.

Conclusion: The Building, Bridging, Being theory contributes to the present understanding of the transition to clinical practice for midwives in Ontario. This study highlighted the importance of strengthening the Preparation, Orientation, Mentorship, and Ongoing Education of new registrants through their transition to clinical practice. The findings of this study are relevant to individuals and organizations invested in educating and integrating midwives into the Ontario health care system and provides a starting point for further research centered on the transition to clinical practice for midwives in Ontario and throughout Canada.

Acknowledgements

I would like to thank my thesis committee, Dr. Beth Murray Davis, Prof. Eileen Hutton, and Dr. Meredith Vanstone, for your encouragement throughout the research and writing process. As a new researcher, your input, feedback, patience, and guidance was invaluable and much appreciated.

Thank you to the midwives who participated in this study. By generously sharing your experiences and insights, you have contributed to research that is both relevant and timely for midwives in Ontario.

To my husband, Jeremy: thank you for consistently supporting me and encouraging me to carve out the time and space that I needed among all our other life commitments. To my children, Juniper and Caspian: you have been alive for as long as I have been working on this project and continue to be the most joyful forces in my life. Finally, to my dear family and friends, Mom & Dad, Karen & Tom, Catherine, Adrienne, and Melissa: thank you for generously contributing your knowledge, motivation, ideas, love, and support.

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List of Abbreviations

AOM	Association of Ontario Midwives
BCC	Billable course of care
CAM	Canadian Association of Midwives
CMO	College of Midwives of Ontario
CMRE	Canadian Midwifery Registration Exam
IMPP	International Midwifery Preregistration Program
MEP	Midwifery Education Program
MFYP	Midwifery First Year of Practice Program
MOHLTC	Ministry of Health and Long Term Care
TPA	Transfer Payment Agency

List of Terms

Full scope	Midwives who maintain care for low risk clients who require oxytocin infusion for induction or augmentation of labour and/or epidural analgesia
Limited scope	Midwives who are required to transfer care to an obstetrician when a client requires epidural analgesia and/or oxytocin infusion for labour induction or augmentation
New registrant	Registered midwife in the first year of independent clinical practice
Primary midwife	Midwife who assumes responsibility for the care of a women during the intrapartum and immediate postpartum period (1)
Second midwife	Midwife in attendance at a birth who assumes responsibility for the immediate assessment and care of the newborn following birth (2)
Second attendant	Someone, other than a registered midwife, who is authorized by the College of Midwives of Ontario (CMO) to assist at midwife-attended births instead of a second midwife. A second attendant must possess the knowledge, skills, and appropriate training to assist in labour, birth, and immediate postpartum care, including assisting in obstetrical emergencies (3)
Primary call	Call model where midwives carry a caseload of four clients per month; Off call time typically includes one or two weekends off call per month and two to three months vacation per calendar year
Shared call	Call model where midwives work in teams of two to four and clients are assigned to a team rather than to a particular midwife; Midwives within the team rotate call coverage with at least one midwife from the team on call at any time

Declaration of Academic Achievement

Under the guidance of my thesis supervisor Dr. Beth Murray Davis and committee members Prof. Eileen Hutton and Dr. Meredith Vanstone, I designed and carried out the study reported in this thesis. I conducted a review of the relevant literature, prepared the research protocol, applied for and obtained ethics approval. I recruited and interviewed participants and analyzed the data included in this study. The Building, Bridging, Being theory that emerged from the findings of this study was developed by myself, then reviewed and adapted with the valuable input from my thesis committee. I have presented preliminary data from this study and earlier versions of the Building, Bridging, Being theory at several academic conferences in an effort to disseminate the findings of this study to the wider midwifery community.

1. Introduction and Background

1.1 Introduction

The transition from student to clinician is a phenomenon that all health care professionals must experience as they leave behind their familiar identity as a student and assume a new professional role and identity. While some stress and anxiety is expected when starting any new job, few roles carry the same high-stakes responsibilities that characterize health care professions; midwifery is no exception. Although the transition to clinical practice has been studied extensively in many fields of health care, including medicine, nursing, occupational therapy, and midwifery outside of Canada, the transition experience for midwives in Canada remains largely unexamined.

Midwives occupy a unique position in the Canadian health care system because they provide primary care in both the hospital and the community setting, work interprofessionally with nurses, physicians, and allied health professionals, have a model of care that requires extensive time on call, and complete a direct-entry education program that does not require a prior college or university background.

Midwifery is a rapidly growing field of health care across Canada. Over the last decade, Ontario has seen the number of midwives increase by 244%, with nearly 90 new Ontario midwifery graduates entering the profession annually (4). As the number of midwives in Ontario grows, it is essential to examine how

these new midwives – referred to as *new registrants* – experience the transition from student to clinician. Scholarship on midwives' transition to professional practice will help illuminate the current systems that support new registrants, and will also identify areas where improvements could be made to better integrate new midwives. Using a grounded theory methodology, this qualitative research study answered the question: *How do new registrant midwives in Ontario navigate the transition from student to clinician during their first year of clinical practice?*

1.2 Background: Ontario Midwifery

1.2.1 *Ontario Midwifery: Regulation and Registration*

Midwifery is regulated and funded in all provincial and territorial health care programs across Canada except for two: Prince Edward Island and Yukon (5). According to the Canadian Association of Midwives, the number of midwives in Canada is over 1500, with approximately 52% of these midwives practicing in Ontario (5,6). Midwifery across Canada is a self-regulated profession wherein midwives maintain membership to their provincial regulatory college. In Ontario, this professional organizations is the College of Midwives of Ontario (CMO). The CMO functions similarly to other medical colleges; it sets guidelines within which midwives must practice and determines what is required for ongoing registration and clinical competency. Most midwives also maintain membership to their respective provincial midwifery association; in Ontario, this is the Association of

Ontario Midwives (AOM). The role of the AOM is to support midwives and the midwifery profession as a whole (7). The work of the AOM includes advocating for and representing midwives within the Ontario health care system, negotiating and providing professional liability insurance to midwife members, publishing clinical practice guidelines, and offering a variety of educational and professional development opportunities for midwives (7).

Midwifery in Ontario is guided by three tenets: choice of birthplace, continuity of care, and informed choice (8). Ontario midwives work in autonomous midwifery clinics and hold admitting privileges at local hospitals. Midwives across Canada provide 24-hour on call primary care to low-risk clients during pregnancy, labour, birth, and for six-weeks postpartum, and for newborns from birth to six-weeks of age (9). As primary maternity care providers, midwives follow the same appointment schedule as family physicians and obstetricians who provide antenatal care. Midwifery clients have similar access to screening tests, lab work, and ultrasounds as those individuals who choose to see a physician during their pregnancy. During labour, a *primary midwife* attends the client for the duration of the active stage of labour, assuming clinical responsibility for monitoring throughout the labour. When the time of birth is approaching, the primary midwife calls a *second midwife* to attend so that there are two registered midwives in attendance at every birth (2). In the place of a second midwife, some practices utilize *second attendants*. A second attendant is someone, other than a registered midwife, who is authorized by the CMO to assist at midwife-attended

births instead of a second midwife. A second attendant must possess the knowledge, skills, and appropriate training to assist in labour, birth, and immediate postpartum care, including assisting in obstetrical emergencies (3). A second attendant may be a health care professional, such as a registered nurse or a physician, or may be an individual who has completed training with the specific purpose of working as a second attendant (3). The 103 midwifery clinics in Ontario vary in terms of the number of active midwives working at each practice, the urban or rural community in which they are located, the on call schedule of the midwives at the practice, and the scope of clinical care offered to midwifery clients in their community.

1.2.2 *Ontario Midwifery: Scope of Practice*

Scope of practice refers to a midwife's clinical responsibilities; particularly what clinical situations a midwife has the training and skills to manage. Midwives provide comprehensive care for low-risk women throughout their pregnancy, labour and birth. They provide six weeks of postpartum care for mother and baby (2,8). The scope of midwifery care in Ontario aligns with the International Definition of the Midwife adopted by the International Confederation of Midwives (ICM) (10). The CMO outlines what clinical situations are included in a midwife's scope of practice and when midwives are required to consult with or transfer care to a physician (11). There are a number of clinical situations, in particular, managing the clinical care for clients who have epidural analgesia and clients who require oxytocin induction and augmentation, for which the scope differs

among midwifery practices and hospitals. According to the CMO, managing the care of clients who have epidural analgesia or whose labour is being induced or augmented with oxytocin are both within the scope of midwifery practice (12,13). According to the CMO, in both of these situations, once the appropriate consultation with an obstetrician, family physician, or anesthesiologist has occurred, midwives may continue to manage the clinical care of the client (14). Within the profession, when midwives maintain care for oxytocin induction, augmentation and epidural analgesia, this is known as *full scope* midwifery care. When midwives are required to transfer care for one or both of these procedures, this is known as *limited scope* midwifery care. In some cases hospitals place additional limitations on the scope that midwives, requiring them to transfer care to an obstetrician if a client requires oxytocin infusion or epidural analgesia; in other cases it is the midwifery practice that chooses not to maintain care in these clinical situations. In 2011, the AOM issued a statement supporting midwives to work to their fullest scope and maintain care for clients who access induction, augmentation, and epidural during labour (15). According to this statement, maintaining primary care through these interventions offers a number of benefits, including keeping birth as normal as possible, enhancing continuity of care, maximizing efficient use of health care resources, and fostering interprofessional relationships (15). Despite these benefits of practicing full scope midwifery, approximately 50% of midwives in Ontario transfer care to an obstetrician when clients require oxytocin induction or augmentation (14).

1.2.3 *Ontario Midwifery: Choice of Birthplace*

Choice of birthplace is one of the three tenets of Ontario midwifery care (8). Midwives maintain admitting privileges at one or more hospitals within their catchment area, allowing clients to choose to deliver either in hospital or out of hospital (14). While approximately 80% of Ontario midwifery clients choose hospital birth, clients choosing out-of-hospital birth may opt to deliver at home or at one of the two birth centers in Ontario, located in Ottawa and Toronto (14,16). At the hospitals where they maintain privileges, midwives must be familiar with and operate in accordance with the institutional protocols related to clinical care, documentation, consultation, and maintenance of hospital privileges.

1.2.4 *Ontario Midwifery: Clinics, Caseloads, and Call Schedules*

Midwifery practices vary in size from small, solo and two-midwife practices, typically in remote and rural areas, to large practices with upwards of 15 midwives in urban centers such as Toronto, Ottawa, and Hamilton (17). A midwife taking on a full caseload provides primary care to approximately 40 clients per year. There are a variety of call schedules that midwifery practices utilize; however, the two most common models are the *primary call* model and the *shared call* model. In the primary call model, individual midwives book four clients with estimated delivery dates in a given month, and have approximately eight weeks vacation per year taken in two- to four-week blocks. During the on call months, midwives have one to two weekends off call where another midwife at the practice provides call coverage to the off call midwife.

An increasing number of practices are adopting shared call models. Shared call models are organized in a variety of different ways, depending on the needs of the midwives. In general, midwives are grouped into teams of two to four midwives and clients are assigned to a team rather than to an individual midwife. The midwives within the team rotate call coverage, with at least one team member being on call at all times. Over the course of their antenatal care, clients meet all of the midwives on their team, the goal being that clients will be familiar with all members of their midwifery team, regardless of who is on call at the time of their birth. Midwives practicing in a shared call model may take on a full caseload of 40 clients per midwife or may choose to reduce their annual caseload. If all midwives working in a shared call team take on a full caseload of four clients per month, the number of clients an on call midwife is providing care for increases proportionally. For example, in a primary call model, at any given time a midwife is on call for approximately four term, thirty prenatal, and six postpartum clients. In a shared call model where a team of three midwives each books a full caseload, at any one time a midwife may be on call for approximately twelve term, ninety prenatal, and eighteen postpartum clients. As one may expect based on these numbers, the on call time for midwives working in shared call models is usually more demanding; however, these models may appeal to some midwives because practitioners are on call for fewer days over the course of the year. There is currently no literature examining the various call models applied across Ontario, why midwives prefer primary or shared call models, or

what impact, if any, call models have on midwives' job satisfaction, client care, or students within the midwifery practice.

1.2.5 *Ontario Midwifery: Funding and Remuneration*

Midwifery care is funded through the Ontario Ministry of Health and Long-Term Care (MOHLTC) and is free for individuals with coverage through the Ontario Health Insurance Plan (OHIP) and also clients who do not have OHIP coverage. The MOHLTC funds midwifery practice groups, rather than individual midwives and practice groups obtain funding through Transfer Payment Agencies (TPAs) according to a provincial agreement (14). Midwives are compensated individually through the TPA and are paid a set fee per billable course of care (BCC) which includes all care provided during pregnancy, labour, birth, and six-weeks postpartum (14). A midwifery practice's TPA approves the number of total BCCs that a midwifery practice may bill for annually.

Midwifery practice groups apply for separate funding to hire new registrants, thus the BCCs that are billed by new registrants are separate from the total annual BCCs allocated to a midwifery practice group. Following the completion of the new registrant's allocated 30 BCCs, the new registrant may be able to continue working at their current midwifery practice if the practice has sufficient funding to support the caseload and BCCs of an additional general registrant midwife. If a midwifery practice is unable to accommodate the caseload once the new registrant completes the required new registrant year

numbers, the new midwife is required to move to a different midwifery practice that has sufficient on-going caseload available to support another midwife.

1.3 Background: Midwifery Education

1.3.1 *Midwifery Education: Overview*

There are two avenues through which midwives in Canada may become registered. Individuals complete a four-year Bachelor of Health Sciences program at one of seven Canadian universities that offers a Midwifery Education Program (MEP) (18,19). All MEPs are university-based, direct entry, four-year baccalaureate degree programs (18). Alternatively, individuals who have practiced midwifery outside of Canada can obtain qualification through a nine-month bridging program that is offered through Ryerson University or the University of British Columbia (20,21).

1.3.2 *Midwifery Education: The Ontario Midwifery Education Program*

There are three universities in Ontario that offer the Ontario MEP: Laurentian University in Sudbury, McMaster University in Hamilton, and Ryerson University in Toronto. The four-year midwifery curriculum is comprised of classroom learning and clinical placements. Over the course of the four-year program, Ontario midwifery students complete a total of 56 weeks of placements in midwifery clinics and 18-weeks in related community settings (18). When midwifery students first embark on the clinical placement component of their education, they are supervised closely by their clinical preceptor as they gain

increasing confidence and competence in all of the clinical skills relating to midwifery care. As they progress through their clinical placements, midwifery students take on increasing responsibilities across all areas of clinical care. By the final clerkship placement, although still under the supervision of a clinical preceptor, midwifery students are expected to take on the complete responsibilities of full-scope midwifery, providing primary care to clients as if the clients were their own (18,22). Whereas at the beginning of their clinical placements students are closely supervised and guided by their preceptors, in their final semester, midwifery clerks are expected to exhibit competence in most areas of clinical care. Midwifery clerks may conduct prenatal visits independently, provided a registered midwife is on-site for consultation, and may conduct up to three postpartum home or clinic visits without another midwife in attendance. Additionally, a registered midwife may call a midwifery clerk to attend deliveries at both home and hospital in the role of the second midwife (22).

Clinical placements are determined by lottery, and although midwifery students may request their preferred geographic location, they have little control over where clinical placements take place and thus have limited control over their exposure to various aspects of midwifery practice. For example, students who complete their final placement year at a limited scope practice where they are required to transfer care for epidural analgesia and oxytocin induction or augmentation are likely to have less exposure to these interventions compared to students who complete their final year of training alongside midwives practicing

full scope. There is currently no research describing what impact, if any, this variation in midwifery students' experience has on their preparedness for clinical practice upon graduation.

Although the MEP endeavors to provide students with the experiences and learning opportunities necessary to prepare them for clinical practice, the current curricular model allows for variation in the students' learning experiences and clinical encounters. Given that variation in learning opportunities exist over the course of the MEP clinical curriculum, it is important to understand how these factors influence the transitional experience of new registrants.

1.4 Background: New Registrants

1.4.1 *New Registrants: Overview*

Approximately 140 midwives graduate from Canadian midwifery education programs annually, with the majority – approximately 90 – graduating in Ontario (19). Once a midwifery student graduates from a recognized Canadian MEP or bridging program, they must successfully complete the national licensing exam, the Canadian Midwifery Registration Examination (CMRE) (23). Following successful completion of the CMRE, new graduates apply to their respective provincial midwifery college to obtain registration under the category of *new registrant* (24). Each provincial midwifery college has their own new registrant policy that outlines what clinical encounters must be demonstrated over the

course of the new registrant year, and outlines any restrictions to clinical practice during the new registrant period.

1.4.2 *New Registrants: Registration and Regulation in Ontario*

In Ontario, the New Registrant Policy published by the CMO outlines the restrictions to clinical practice and requirements that new registrants must meet during their first year of clinical work (24). The CMO requires new registrants to work at an established midwifery practice for a minimum of 12-months (24). An established practice is defined as a practice that has midwives who have been funded for at least one year and who currently hold hospital privileges in the community being served (25). During their new registrant year, midwives must attend a total of 60 births – 30 in the role of the primary midwife, and 30 in the role of the second midwife (24). Of these 30 primary and 30 secondary births, a maximum of 20% of each may be attended with another new registrant and none may be conducted with a second attendant (3,25). A new registrant may choose to complete a portion of their new registrant requirements outside of Ontario; however, a minimum of six-months of the new registrant year must take place in Ontario (25). The final CMO restriction to new registrant practice applies to an individual working at practice where there is only one other midwife; in this situation, the new registrant is required to participate in monthly peer review meetings with at least one other midwifery practice (25).

Once a new registrant has attended 30 births each as the primary and the second midwife, she may then apply to the CMO for a change of status from new

registrant to *general registrant, with conditions*. With this status, the midwife may now attend births with another new registrant or with a second attendant, but is still required to work at an established midwifery practice until 12-months from the date of registration (26). Following the new registrant's year at an established practice, the midwife's status becomes *general registrant*, *without conditions* (26).

1.4.3 *New Registrants: Orientation, Supervision, and Mentorship*

In Ontario, aside from the requirements and restrictions set by the CMO in the New Registrant Policy, discussed above, there are no formal guidelines to facilitate transition, orientation, or mentorship during the first year of clinical practice. With no systems or regulations in place to guide midwifery practices, there is the potential for significant variation with respect to the support, mentorship, and supervision that new registrants receive during the first year of clinical practice. While some midwifery practices have independently established their own orientation, supervision, and mentorship protocols, other practices take a more informal approach to integrating new registrants into their practice.

Many midwifery practices and hospitals require that midwives who are new to the community and who are applying for hospital privileges, new registrants included, conduct a specified number of births with another midwife in attendance for supervision. The number of supervised births is highly variable across communities and in some cases may be entirely up to the discretion of the new registrant based on their own perceived learning needs. In communities where managing epidural analgesia and oxytocin inductions and augmentations are part

of the midwifery scope, a supervised number of each of these procedures may be required before full hospital privileges are granted. These supervision numbers are not defined by the CMO but are instead based on numbers set by individual midwifery practice or hospital policies. As such, the supervision requirements during the first year of practice are highly variable across the province.

It has been well established in the literature regarding the transition to clinical practice in other health care fields that having a consistent mentor is helpful in developing strategies to address the demands of clinical practice (27–32). While there are currently no policies or guidelines that discuss new registrants accessing the support of a mentor during their first year of clinical practice, midwifery practices can access funding through their TPA to support midwifery mentors. This funding compensates mentors for activities such as providing orientation to clinical, hospital, and professional systems and protocols, as well as on call clinical support in the form of remote or in-person advice and supervision (33). While financially supporting midwifery mentors is certainly helpful, individual midwifery practices are responsible for outlining the details regarding the structure of their own mentorship programs, and defining the roles, responsibilities, and expectations within the mentor-new registrant relationship.

1.5 Background Summary

Midwives occupy a unique place in the Canadian health care system in providing primary care for low-risk clients throughout the pregnancy, labour, birth, and postpartum periods. As a direct-entry university program, the MEP relies

heavily on clinical placements to provide midwifery students with the client encounters, interprofessional discussions, and practical administrative experiences that will prepare students for professional practice as new registrants. The next chapter examines the literature surrounding the transition to clinical practice in health care fields outside of midwifery and explores the Canadian midwifery research that is relevant to the transition to clinical practice for new registrant midwives in Ontario.

2. Literature Review

2.1 Literature: Introduction

There are two bodies of literature directly relevant to new registrant midwives' transition to clinical practice: the relatively large amount of scholarship dedicated to other health care professionals' transition to professional practice, and the smaller group of studies related to Canadian midwives' transition to professional practice. Although there is little scholarship regarding the transition to clinical practice for health care professionals in the Canadian and Ontario midwifery contexts, there is a considerable body of research examining the transition to clinical practice for physicians, nurses, hospital-based midwives[1], and other allied health professionals such as occupational therapists and physiotherapists. Taken together, trends from these studies can serve as a baseline of comparison for midwifery in Ontario.

In reviewing the literature regarding the transition to clinical practice in a variety of health care professions, themes related to challenges with the transition to practice become evident. In particular, the transition to clinical practice for health care professionals includes challenges related to clinical responsibility, personal and professional support systems, and professional identity.

[1] Midwives in the UK and Australia are most often employees of the health service or local hospitals and do not carry an independent caseload of clients. As such, these midwives do not generally provide on call care, but instead work either on a hospital maternity ward providing intrapartum care, or in a hospital or community clinic conducting antenatal and postpartum visits. This model is unlike Canadian midwives who work on call to provide primary, continuous care throughout the antenatal, intrapartum, and postpartum periods.

The studies related to Canadian midwifery address issues such as how prepared new registrants feel when they start clinical practice and what factors during the first years of clinical practice influence long term retention of midwives. These Canadian studies provide a starting point to see what literature is available in the Canadian midwifery context, and what remains to be examined.

2.1.1 *Clinical Responsibility*

A common thread throughout the literature examining the transition to clinical practice is the weight of responsibility that new health care practitioners feel upon graduation (27,28,30,34–40). With the increased depth and breadth of clinical responsibility that is required as new graduates move from student to practitioner, often comes feelings of unpreparedness (35,37,38,41–44). In addition to increased responsibility, new practitioners are often unaccustomed to managing the volume of patient care required upon graduation, and must learn to prioritize and organize independently (27–31,35–48). The feelings of anxiety that come with juggling increased responsibility and workload may be compounded by new practitioners' lack of confidence in their own clinical skills (28–30,38,40–42,48–51). When new graduates do not perform as well as they had as students, they are disappointed in themselves and question their own competence (34,46,50). Feelings of inadequacy may be intensified if colleagues perceive a lack of knowledge as a weakness, rather than as a part of the normal transition process (34,37,39,46,50). New graduates gradually overcome the initial shock of the transition to clinical practice as they develop strategies to organize and

prioritize their time, and when they gain confidence in their skills through successfully dealing with challenging clinical situations (27,34,36,41,43,46,47,50,52,53). A key element of making this transition, is building positive, professional relationships with colleagues.

2.1.2 *Support Systems*

One of the ways that health care practitioners learn to manage the increased responsibilities of clinical practice is by building relationships with colleagues in their new workplace. While some new graduates have positive experiences integrating with their new health care team, many graduates encounter negative experiences of exclusion, intimidation, powerlessness, and uncertainty of whom they can approach for support (28–30,32,35,46,48). A similar sentiment was echoed in Cameron's study of Ontario midwives who experienced negative interprofessional relationships and felt unduly scrutinized by hospital colleagues (54). For health care professional students, peers, tutors, and faculty form a supportive network through which learners can address clinical, professional, and ideological challenges. In the work environment, graduates are no longer connected to such support systems, and instead must build new support networks.

New graduates from all disciplines identify that having a trusted mentor in their new workplace helps ease the transition to clinical practice (40,42,46,49,50,55). In contrast to the role of a clinical preceptor, whose primary responsibility is clinical teaching, the role of a mentor is to share their knowledge

and perspective with a less-experienced colleague with the purpose of advancing their career (56–58). While the role of a clinical preceptor is instituted for a specific purpose and period of time, mentorship offers a long-term relationship and the purpose depends greatly on the needs of the mentee (56,58). A mentor can assist with all aspects of transition, including orienting the new graduate to the clinical environment or community, introducing them to other members of the health care team, helping develop strategies for organization and prioritization, and offering a safe and encouraging environment to practice clinical skills (27–29,31,32,39,43,48,50,59). In facilities where there is no formalized mentorship program for health care professionals, graduates receive less constructive feedback and commonly recommend structured mentorship programs be implemented for future graduates (30,31,34,38,39,46,48,59,60).

While much of the literature related to structured mentorship programs in health care focuses on mentorship in nursing within larger health care institutions, the mentorship model for midwifery in New Zealand is notable because it is situated in a midwifery context that is similar to the midwifery model throughout Canada; where midwives are community-based, self-employed, and carry a caseload of clients (61). In New Zealand, newly graduated midwives participate in the Midwifery First Year of Practice Program (MFYP), which is a formal, regulated, and funded mentorship program that includes mentor training, a professional framework, and monitoring new practitioners' progress (56). In this model, mentors provide support, advice, and education that is directly related to

the learning needs, professional goals, and mentorship expectations set out between the new midwife and the mentor (56).

2.1.3 *Professional Identity*

The literature surrounding the development of professional identity in various fields of health care outlines stages that graduates experience as they cultivate their professional identity (62). The development of one's professional identity begins as a student and continues through the initiation and advancement of clinical practice (62). While students generally look forward to graduating and to developing their professional identity, for many, the abrupt transition from student to clinician puts new graduates in a position where they are no longer in the familiar student world, yet have not developed the confidence that allows them to identify with their professional role (39–41,46,50,51). As graduates develop stronger relationships with colleagues and become more confident in their clinical skills, they are able to better identify themselves as a members of their profession, rather than as a students (34,47). Increased experience with clinical responsibilities, developing deeper collegial relationships, and understanding the nuanced values, expectations, and behaviours of their particular profession helps graduates to function independently with confidence, exercise critical thinking skills, and to see themselves as contributing members of the health care team (62). These developments enable graduates to move beyond their identity as students and develop their sense of identity as clinicians (27,28,34,36,39,46,47,60).

2.2 Transition to Practice for Canadian Midwives

The body of literature examining the transition from student to clinician suggests that common challenges and experiences exist across professions for registered nurses, nurse practitioners, occupational therapists, and midwives outside of Canada. While the scholarship surrounding the transition to clinical practice for Canadian midwives is certainly less comprehensive, two Canadian studies have examined the self-reported preparedness for clinical practice of new midwifery graduates. Kaufman (2007) and Ellis (2013) surveyed midwifery graduates in Ontario and British Columbia, respectively (63,64). Similar to the findings of studies examining the transition to clinical practice for other health care professionals, new midwives required assistance with organizing and scheduling the demands of a full caseload, managing interprofessional relationships, and understanding the business and financial aspects of midwifery practice (63,64). Graduates viewed clinical placements as highly valuable elements of their midwifery education, providing effective learning environments in which to develop clinical skills related to all aspects of midwifery care through pregnancy, labour, birth, and postpartum periods (18,63,64). In both of these studies, graduates perceived that, overall, they were prepared for clinical practice (63,64). From the perspective of mentors working with new registrants, while the new graduates' clinical skills were adequate, mentors felt that new registrants were not fully prepared for the realities of autonomous midwifery practice (64). While these two studies identify common features of the new registrant

experience, they do not go into great depth of describing the transition process that new midwives experience.

2.2.1 *Midwifery Retention and Attrition*

The sustainability of midwifery hinges on a complex network of factors that were explored through two 2010 studies examining midwifery retention and attrition in Ontario (54,65). The authors observed that many midwives entered the profession with great optimism and excitement and that their self-identity was closely linked to their professional identity as a midwife (54,65). Midwives who remained in clinical practice enjoyed their work, wanted to make a difference in the lives of clients, and had positive relationships with colleagues with whom they shared a similar philosophy (65). Examining those midwives who left clinical practice, Cameron found that between 1994-2007 the attrition rate for midwives in Ontario was 21% (54). Although the reasons for leaving the profession were complex, many midwives cited the stress of an on call lifestyle and the difficulty in attaining work-life balance as key reasons for leaving midwifery (54). Challenging relationships with clients, other midwives, and interprofessional colleagues were also factors that influenced midwives' decisions to leave the profession (54).

Midwives experienced significant disappointment when their - perhaps idealized - expectations of what it meant to be a midwife were not met upon entering clinical practice (54). This finding aligns with research from other health care fields showing that new practitioners commonly experience feelings of

frustration and disillusionment with the realization that their student perception of what clinical work would entail does not align with the realities of clinical practice (31,35,39,40,53). The gap between idealistic expectations and reality is evident in areas that include the quality of health care provided to patients, relationships with colleagues, and differences in philosophies of care (34,35,41). Cameron found that for some midwives it becomes impossible to reconcile their previous perceptions of midwifery with the realities of clinical practice, and this discordance drives them entirely from the profession (54).

Another study conducted in 2007 examined attrition of students in the Ontario MEP (66). While the academic portion of the midwifery education program is rigorous, academic challenges were not central to students leaving the program. This study found that the key challenges for midwifery students included: relocating for clinical placements, managing conflict with clinical preceptors, and adapting to the clinical responsibilities of midwifery care (66). Individuals who left the MEP reported that, when faced with these challenges, the support systems that they had access to were inadequate, leading to a decision to leave the program (66). The findings of Wilson's study suggest that enhancing student support systems during the midwifery education program may be fundamental to helping students manage the common stresses involved with the student experience; particularly, relocation for clinical placement, conflict with clinical preceptors, accepting the clinical responsibilities of the midwifery profession, and balancing one's personal and professional life (66).

While the decision to leave the midwifery profession as a student or after commencing clinical practice is perhaps an extreme outcome, these studies highlight some of the obstacles that midwifery learners and beginning practitioners all experience to a greater or lesser degree. The support systems that a midwife has in place influence her ability to cope with the challenges of clinical practice. Versaevel found that one's partner, work colleagues, and family were the fundamental sources of support for midwives. Midwives who left the profession expressed that they did not receive adequate support from senior midwifery colleagues (54,65). These findings, along with the findings of Wilson's study of attrition of midwifery students, draws attention to the importance of support from midwifery colleagues in overall midwifery retention and emphasizes the need for supporting and mentoring both midwifery students and new registrants. As new registrants enter clinical practice, they will undoubtedly encounter challenging aspects of midwifery, and a process ensuring that new midwives receive adequate support during their new registrant year may help create a solid foundation to promote overall retention within the profession (54,65).

2.3 Literature Review: Summary

The literature exploring the transition to clinical practice identifies some key elements that are common across health care professions. Specifically, when first starting clinical practice, new graduates often grapple with the weight of clinical responsibility, seek to develop professional support networks, and have

difficulty identifying with their profession. These findings provide a foundation from which one can begin to explore the experience of new registrant midwives in Ontario, to determine whether midwives experience similar challenges during their transition to clinical practice.

The studies by Kaufman (2007) and Ellis (2011) examine the clinical preparedness of new registrants in the Canadian midwifery context, and their findings suggest that Canadian midwives share some of the same challenges that other health care professionals experience during the transition to clinical practice (63,64). These two studies focused primarily on the clinical preparedness of new registrants and identified which aspects of the midwifery education program new graduates found to be most helpful in developing the clinical skills new registrants need for professional practice (63,64). A limitation of these studies is that neither of them explored the other elements that influence the transition to clinical practice such as the weight of clinical responsibility, the importance of building support systems, or the development of a professional identity. Although Ellis did identify some areas of weakness in new graduates, namely adjusting to workload and needing emotional support, these areas were identified by the midwifery mentors surveyed in her study, not by the new registrants themselves (64). Furthermore, while Ellis's study acknowledged the importance of mentorship during the new registrant year, this study was conducted in British Columbia where, similar to Ontario, the College of Midwives of British Columbia does not have standard policy that outlines the roles and

responsibilities of a mentor (67). Without a definition of a mentor or standard guidelines for mentor responsibilities, it is difficult to determine what support mentors provided to the new registrants in this study. The Canadian studies by Wilson (2013), Cameron (2011) and Versaevel (2011) identified that support during midwifery education and the first years of clinical practice has a positive effect on midwives' overall retention; however, these studies did not explore what type of support was the most beneficial or suggested how to improve support and mentorship across the midwifery profession (54,65,66).

The transition to clinical practice for Canadian midwives demands further exploration: a more nuanced characterization of how new registrants experience the transition to clinical practice and the support new registrants value during the transition to clinical practice is absent from the Canadian scholarship on midwifery education, practice, and policy.

3. Methodology

3.1 Introduction

As described in the review of relevant literature in chapter two, the transition to clinical practice for new registrant midwives in Canada is a field of research yet to be fully explored. In considering the scope and feasibility of this research project, the researcher, in collaboration with her thesis committee, decided to limit this study to new registrants in Ontario. Qualitative research methods, such as grounded theory, are commonly used to examine areas of research that have not been thoroughly examined in the literature (68). Grounded theory research methodology, in particular, uses qualitative data to develop a theoretical explanation for the phenomenon being studied. The purpose of this study was to use grounded theory methodology to develop a theoretical framework to describe the experience of new registrant midwives as they transition from student to clinician during the first year of clinical practice (68). Grounded theorists use either an objectivist or a constructivist worldview when designing studies and interpreting research data (69). While the objectivist worldview claims that it is possible to discover a definitive truth about a phenomenon or experience, the constructivist worldview asserts that one, single truth does not exist, but instead is interpreted by the researcher (69). This study utilized an objectivist approach with the understanding that, while study participants contributed varying perspectives and unique experiences, the overall

theory emerged trough the research data from participants and represents a knowable reality regarding the transition to clinical practice. This study received ethics approval through the Hamilton Integrated Research Ethics Board (REB Project #11-409).

3.2 Participant Sampling and Recruitment

One of the key philosophical elements of grounded theory is that it is impossible to separate the experience of an event from the social, political, and cultural context in which the event takes place (68). Because of the complex interactions within any situation or phenomenon, a researcher must explore an event from multiple perspectives in order to gain a complete understanding of the topic in question (68). In an attempt to establish a comprehensive picture of the transition to clinical practice for new midwives, this study explored the experience from multiple perspectives by including three participant groups: new registrants, midwives who had been practicing for one to five years, and midwives who acted as formal or informal supervisors or mentors for new registrants. Inclusion and exclusion criteria were established for each participant group (Table 1 – Inclusion and Exclusion Criteria by Participant Group).

	INCLUSION	EXCLUSION
Group A	• Practicing midwifery in Ontario • <12 months clinical practice • Graduate from Ontario MEP	• Graduate from IMPP • Previous career in another field of health care
Group B	• Practicing midwifery in Ontario • 1-5 years clinical practice • Graduate from Ontario MEP	• Graduate from IMPP • Previous career in another field of health care
Group C	• Practicing midwifery in Ontario • Self-identify as working with new registrants as supervisor or mentor	N/A

Table 1 - Inclusion and Exclusion Criteria by Participant Group

The first participant group, Group A, consisted of new registrant midwives from across Ontario. This group included midwives who had graduated from one of the three Ontario Midwifery Education Programs (MEPs) and who were completing their new registrant year at an Ontario midwifery practice. Because this study examined the experience of transitioning from student to clinician, new registrants who had previously worked as a midwife in a country outside of Canada and who were completing their first year of practice after qualifying through the International Midwifery Preregistration Program (IMPP) were excluded from this study. Similarly, new registrants who had worked in another health care field were excluded because they had previously experienced the transition from student to clinician. Participants in Group A were able to share their perspective with the transition to clinical practice as they were experiencing it at the time of the interview.

The second participant group of this study, Group B, included midwives who had been practicing in Ontario for one to five years. The rationale for including this participant group was to gain the perspective of midwives who were

not currently in their first year of clinical practice, but who had experienced this phenomenon in the recent past. These midwives were able to reflect on their experience transitioning to clinical practice with the additional context of more clinical experience and perspective. The midwives included in this group were also required to have graduated from an Ontario MEP and had completed their new registrant year at an Ontario midwifery practice. Similar to Group A, this group excluded internationally-trained midwives who became registered through the IMPP and midwives who had experienced the transition from student to clinician in another field of health care.

The third participant group, Group C, was comprised of midwives who identified themselves as having experience working closely with new registrants as supervisors or mentors. These midwives described strategies they used to help facilitate the transition process for the new registrants, including orientation, supervision, and mentorship, and also identified strengths and challenges that they observed through their interaction with new registrants.

The first phase of participant selection employed convenience sampling. Convenience sampling refers to the sampling method of selecting participants based on accessibility (70). A recruitment email was sent to all midwifery practices across Ontario; this contact information is available to the public through the Association of Ontario Midwives website (Appendix A – Recruitment Email). The recruitment email outlined the purpose of the study and requested that midwives who were interested in participating in the study complete an online

recruitment survey. The information collected through the recruitment survey enabled the researcher to select participants based on the inclusion and exclusion criteria, assigned individuals to the appropriate participant groups, and provided the demographic information necessary to perform purposive sampling as the study progressed (Appendix B – Participant Demographic Data).

Social media was also used to recruit study participants directly via the creation of a website, a Facebook page, and a Twitter account specifically for this study; these online resources were subsequently shared with midwifery-related organizations, social media pages, and personal contacts of the researcher (Appendix C – Social Media and Website).

The second phase of recruitment utilized purposive sampling; the method of selecting participants based on the outcomes of initial data analysis. As a sampling technique, purposive sampling is used to maximize the variability of participant characteristics, to ensure a wide range of demographic and sociological variables, and to select participants who have unique experiences (70). In this study, purposive sampling was utilized to recruit two additional participants in order to maximize the diversity of experiences of participants with respect to location and scope of practice. By gathering data from a diverse range of participants, the aim was to develop a theory that was relevant to the wide range of new registrants across the province.

3.3 Data Collection

Data was collected by semi-structured interviews. This interview method allowed participants to guide the flow of information and to bring up topics that they perceived as relevant to their own experience. An interview guide was developed by the researcher and modified based on feedback from the thesis supervisor and committee. Two pilot interviews were conducted; one by the researcher with one of her colleagues, and one by a committee member with the researcher herself. These pilot interviews were not included as part of data collection but helped determine if the wording and flow of interview questions was clear, logical, and relevant, and also gave the researcher a chance to engage in reflexivity about her own transition to practice (see Chapter 3.6). Although the interview guide was used during the interviews, the nature of semi-structured interviews allowed the researcher to adapt the line of inquiry based on topics that participants introduced during the interview (68) (Appendix D – Interview Guide Sample). Each interview began with the researcher reviewing the study consent form, purpose, research question, confidentiality, and anonymization procedures with the interviewee.

Interviews were recorded and transcribed verbatim. Prior to transcription the researcher anonymized participants by assigning each a participant code so that names were not directly associated with interview transcripts. The researcher maintained access to these codes in a password-protected electronic database, in case a participant wanted to withdraw from the study at a later date. For the purpose of using direct quotations to illustrate the findings of this study,

each participant was assigned a pseudonym. The direct quotations used in the subsequent chapters of this study are attributed to these pseudonyms. In order to further maintain the confidentiality and anonymity of participants, the names, locations, and identifying characteristics of colleagues, midwifery practices, catchment areas, hospitals, and other identifiable information were omitted from the interview transcripts and from the findings presented here.

3.4 Data Analysis

In grounded theory, data collection and analysis are closely linked, and data analysis begins when the first set of data is collected (68). The iterative process of data collection and analysis involves breaking down the data into smaller segments, considering possible meanings of the data segments, reflecting on the meaning of various ideas that arise, identifying key concepts, and asking questions that arise from the data (68). The process by which the researcher derives key concepts from raw data is known as *coding* and can be broken down into two main types: *open coding* and *focused coding* (68,71).

Following transcription of the recorded interviews, transcripts were printed and the researcher read through the transcripts in order to become familiar with the content, overall concepts and tone of the interviews (68). Open coding, in the form of line-by-line coding, was performed by the researcher to assign potential meanings to segments of data (68,71). Both researcher-denoted and in-vivo codes were used. Events, actions, interactions, and ideas that emerged from the data were compared with each other for similar themes and out of these themes,

and conceptually similar ideas were grouped together and labeled (71). Following the line-by-line coding of five interview transcripts, the researcher compiled a coding master list. This master list was used when coding subsequent interviews. The process of open coding is an essential element of grounded theory methodology because this process generates new categories and themes, compares new data to previously-identified categories, and refines existing categories (71). During open coding, the researcher developed questions that drove the research process by identifying categories that needed further elaboration (71).

Focused coding includes axial and selective coding techniques. Axial coding is used to relate categories and subcategories to each other and to ensure that the identified categories are supported by sufficient data (71). In conducting axial coding, the researcher explored the context through which each category emerged and gained a deeper understanding of the events or situations that gave rise to the identified categories (71). In order to complete axial coding, the researcher printed out the coding master list and cut out individual codes. Codes were arranged and rearranged in various ways in order for the researcher to visualize the relationship between the elements of the raw data. It was during axial coding that the researcher began to build a theory related to the phenomenon being studied. While the relationships between raw data and theory may start off as hypothetical during axial coding, these links must be confirmed and supported by data through further data collection and analysis

(71). Once preliminary axial codes were identified, the researcher reviewed her findings with her supervisor to determine which categories needed further elaboration. Purposive sampling was then used to select participants for additional interviews.

The final step of the coding process is selective coding. This step typically occurs in the later phases of a study since it is through selective coding that all categories are united by a core category or theme. Before selective coding can be completed successfully, it is imperative that all categories be well-supported by raw data (71). In conducting additional interviews with participants in Groups A and B and analyzing the data from this second round of interviews, this additional data served to strengthen the findings from the initial group of interviews and no additional code categories emerged. Selective coding was performed to identify themes that ran throughout the axial codes.

The cycle of data collection and data analysis through open and focused coding is repeated multiple times throughout the research process. The researcher constantly compares, alters, and generates new concepts based on the association between old and new data and identifies relationships that exist within the data (68). If there are categories that require further exploration, purposive sampling is used to obtain greater depth of information in those particular categories. When no new codes emerge with additional data collection and when all major categories are described with sufficient depth and variation, the researcher can be confident that theoretical saturation has been achieved

(68). Another way of describing theoretical saturation in grounded theory is with the concept of *theoretical sufficiency*, wherein categories and themes appear to accommodate new data without further modification (72).

Unlike quantitative research where the research methods are strictly laid out before beginning data collection, in qualitative research methods, modifications to the research methods may change as the research progresses (71). One key element of grounded theory is that data collection and analysis are an iterative process in which questions, ideas, and emerging themes are used to shape further data collection and analysis (68). In the current study, the researcher kept interview notes and memos throughout data collection and analysis in order to keep track of insights that arose. These memos and notes were then used to shape changes to the interview guide, to outline new ideas and themes, and to guide ongoing purposive sampling (68). As an example of how data analysis informed ongoing data collection in this study, it was discovered during the coding process of the initial set of interviews that the richest information regarding the transition experience of new registrants came from participants in Groups A and B; new registrants, and midwives who had been practicing one to five years. Although participants from Group C also had valuable insight regarding some aspects of the transition to clinical practice, they did not have the same sense of the experience that new registrants have during the first year of clinical practice. For this reason, no additional participants from Group C were recruited.

3.5 Trustworthiness

Validity describes the extent to which the findings of a research study, either quantitative or qualitative, accurately represent what they set out to represent (68). While quantitative standards for rigor include the four categories of internal validity, external validity, reliability, and objectivity, for qualitative research four analogous categories are used: credibility, transferability, dependability, and confirmability (73). The rigor of a qualitative study is referred to as trustworthiness and is dependent on the extent to which a researcher adheres to these four criteria (73).

The first category, credibility, is comparable to the concept of internal validity in quantitative research and describes the degree to which the study findings accurately reflect reality (73). In quantitative research there are several methods of ensuring internal validity, including using randomization and limiting confounding variables. Similarly, in qualitative studies, researchers may use a variety of methods to strengthen the credibility of their work; in this study, triangulation was used to achieve credibility (73). Triangulation refers to using multiple methods of data collection, sources of data, times of data collection, or analysts during the data collection process in order to achieve a rich understanding of the phenomenon being studied (73–76). In this project, triangulation was accomplished by including multiple participant groups and by seeking diversity within these groups. The varying perspectives of the individuals from the three participant groups helped to form a full description of the new

registrant experience. In addition to using three participant groups, the researcher sought diversity within the participant groups so that the perspective of participants was representative of the varying circumstances in which Ontario new registrants practice. The scope of practice, location of practice, the age of the new registrant, whether or not the new registrant has had to change midwifery practices or communities upon graduation, and which midwifery education program the new registrant attended were all sampled for using purposive sampling to ensure diversity within Groups A and B.

Transferability, the second element of trustworthiness in qualitative research, is analogous to the concept of external validity in quantitative research and, in both qualitative and quantitative contexts, refers to the extent to which the results of a research study can be applied to other individuals, groups of people, or situations (73,77). Although the purposes of both transferability and external validity are similar, the manner by which they are achieved differs significantly. In quantitative research, the ability to generalize study findings to a wider population is largely dependent on the composition of the study sample, and thus is highly influenced by the sampling strategies used to generate a study sample group (77). In qualitative research, the way that a researcher achieves transferability is quite different. The goal of qualitative research is to describe a particular phenomenon in a unique context; it is up to the researcher to provide a rich and detailed description of the study context (77). By providing an in-depth picture of the context surrounding the phenomenon being examined, the researcher allows

individuals to judge whether or not the study findings do, in fact, apply to a different situation (73,77). As previously described, the landscape of midwifery varies across the province. In order to create a theoretical framework that is relevant and applicable to the overall new registrant transition experience, the researcher sought to capture diversity within the new registrant voice and to provide transparency with respect to the context in which study participants practice midwifery.

The third criterion that contributes to the trustworthiness of qualitative researcher is dependability (78). This element is comparable to the quantitative concept of reliability, in which research findings can be consistently replicated with similar subjects or in a similar context (78). Since the measurement tools used in quantitative research must be stable and produce replicable results, any significant variation in results is attributed to error (78). In qualitative research, however, the instrument is the human being, and variation and change are expected. For this reason, variation in results in qualitative research is a natural occurrence in any study, and the researcher must delve into the reasons why variation is seen (78). Unlike quantitative research, where methods are precisely planned out prior to commencing data collection, qualitative research is a more fluid process that allows for the researcher to alter data collection tools, such as the interview guide, as findings are obtained and analyzed (68). As methodological changes are made over the course of the research, the researcher must maintain an audit trail to keep thorough track of the process of

data collection and analysis and record the reasoning behind any adjustments that are made to the research process (78). In this study, an audit trail was established through the use of interview notes taken following interviews with impressions that the researcher had immediately following the interviews. Additionally, memos were taken during data analysis and following thesis committee meetings to keep track of methodological decisions that were made throughout the study. Notes from meetings with the thesis supervisor and committee helped support key decisions made over the course of the research. By following the audit trail of the changes made during the research project, one can justify the modifications that occurred during the data collection and analysis phases and can be assured of the dependability of the study findings.

The fourth element of trustworthiness is confirmability, which is akin to the quantitative concept of objectivity (78). In quantitative research, objectivity relies on the researcher removing any bias that may exist through the data collection and analysis process (78). In qualitative research, however, confirmability relies not upon the absence of bias, but rather upon the extent to which the raw data supports the final theory (78). The purpose of confirmability is to enable readers to see the path of reasoning through which the researcher travelled to arrive at the final theory. Within this research project, several elements of the research methodology were put in place to ensure confirmability. Triangulation has already been described as it relates to the credibility of this project. Triangulation is also a strategy used to ensure confirmability when the specific elements of a

theory can be attributed to multiple data sources (78). In this study, three participant groups were used in order to provide links between multiple sources of raw data and the various theoretical elements. Finally, reflexivity allows the reader to follow the researchers own thought process during data collection and interpretation, provides justification for any methodological changes made throughout the research process, and allows the researcher to reveal their own perspectives and assumptions related to the research topic and to declare how their own interest fits in to the research topic (68,74).

In order to ensure the rigor of this study, when considering the methodology of this grounded theory study, the researcher, with input and guidance from her thesis supervisor and committee, addressed the four key elements of trustworthiness: credibility, transferability, dependability, and confirmability.

3.6 Reflexivity

Unlike quantitative research where the researcher must ensure that all bias is removed, in qualitative inquiry the researcher acknowledges their own bias and perspective towards elements of the research project (78). In order to counteract these innate biases, the researcher engages in a process known as reflexivity. Reflexivity involves identifying assumptions, preconceptions, opinions, and biases as well as changes in his or her own perspective over the course of the research process (78). In this project, reflexivity was accomplished in a number of ways. As described previously, prior to conducting interviews with

research participants, two pilot interviews were conducted. The researcher was interviewed by one of her committee members and the researcher conducted a test interview with a midwife colleague. These pilot interviews allowed the researcher to engage in reflexive practice and to consider her own experience as a new registrant midwife and now as a more experienced midwife who works closely with new registrants.

My interest in the transition to clinical practice arises from my own experience moving to a new community as a new registrant, and also from working closely with senior midwifery students and new registrants at my current midwifery practice. As a new registrant, I moved to a new community and was required to adapt to the culture of a new midwifery practice, two new hospitals, full scope practice, and a primary call schedule. Although as a new registrant my practice did have defined supervision requirements, the mentorship was not structured, and I largely found support through informal interactions with my midwifery colleagues and from peers who were completing their new registrant years at other midwifery practices. My experience as a new registrant was generally positive; however, I knew from talking to my peers that the transition to clinical practice was highly variable and I was left wondering if a more structured approach to mentorship would be beneficial.

I continue to work at the midwifery practice were I completed my new registrant year. Each year at this practice we have two to three senior students completing their final year of midwifery education. Although I am not currently a

clinical preceptor for these senior midwifery students, I often work with them clinically. Our practice also typically hires two to three new registrants each year and I have been involved in the hiring and orientation of new registrants for several years.

In order to engage in reflexive practice, before embarking on data collection, I was interviewed by one of my committee members using the interview guide I had developed. At the time of the interview, I would have been stratified to participant Groups B or C, since I had been practicing for approximately five years, and I also worked closely with new registrants at my own midwifery practice. During the interview process, I realized that I did not have many distinct memories from my time as a new registrant and I had difficulty remembering many elements about my transition to clinical practice. Many of my recollections from my new registrant year related to particularly challenging clinical situations and mentorship I received in such situations. Going through this process enhanced my curiosity about the new registrant experience, as I could not clearly remember my own. Through this process I also realized how important it would be for midwives who work with new registrants to be reminded of the challenges that new registrants face, since more experienced midwives may not clearly or accurately remember their own new registrant experience.

Engaging in this reflexive practice helped me to both solidify my interest in this area of research, and to illuminate the extent to which the findings of this

study would be relevant to both new registrants and the broader midwifery profession.

4. Findings

Following the distribution of recruitment emails to the 103 midwifery practices in Ontario, 32 surveys were completed; 12 from Group A, 15 from Group B, and five from Group C. The researcher contacted 27 of these participants by email. Out of the 27 candidates contacted, 12 responded to the follow-up email and the researcher was able to arrange interviews with 11 of these; five from Group A, four from Group B, and two from Group C. One participant responded to the follow-up email, but an interview was not arranged due to scheduling conflicts and the participant's absence from the country during the majority of the data collection phase. One participant fell into both Groups B and C, however most of the information provided was relevant to Group B, so her response was included in Group B. The 15 remaining potential participants did not respond to the follow-up email from the researcher (Figure 1 – Recruitment Flowsheet). Data analysis began following the first round of interviews, which included five participants: two from Group A; two from Group B; and one from Group C. At this stage, the researcher used line-by-line open coding to develop master list containing 267 codes. This coding master list was then used to complete the line-by-line coding of the second round of interviews, which comprised six participants: three from Group A; two from Group B; and one from Group C. Following these two rounds of data collection and analysis, purposive sampling was used to recruit two more study participants. Emails were sent to 12 survey respondents; four from Group A and eight from Group B. Of these 12 follow-up emails, two participants from Group B responded and the researcher was successful

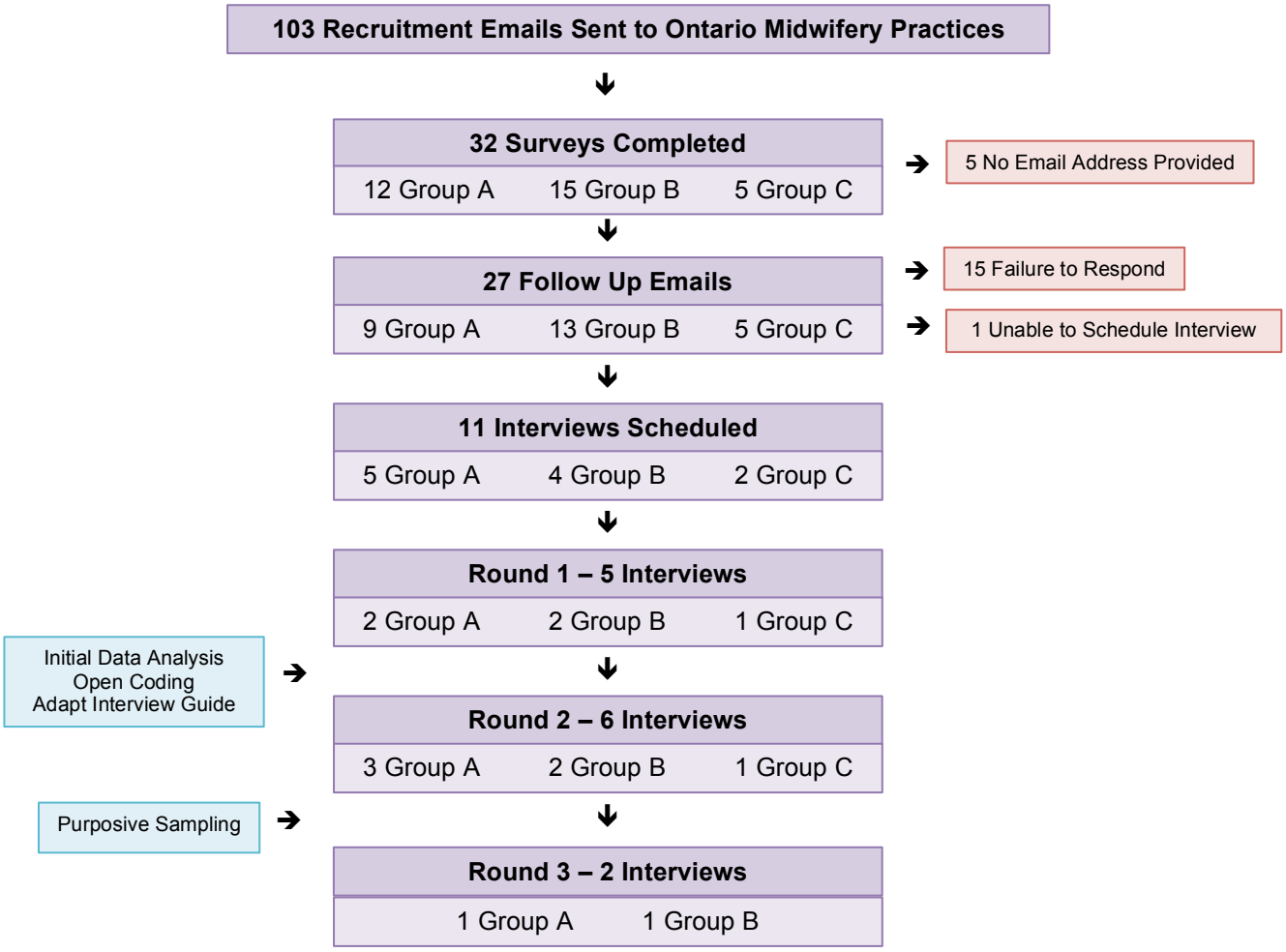

Figure 1 – Recruitment Flowsheet

in arranging an interview with one of these people. One more participant from Group A was recruited through snowball sampling.

Participants were recruited from all over Ontario, and consequently nine interviews took place over the phone or via Skype and four interviews were conducted in person. The midwives included in this study represented the diverse contexts in which midwifery is practiced across Ontario with respect to the size of the midwifery practice, the community in which practices are located as reported by

participants, and the scope of clinical practice within the hospital (Table 2 – Demographic Data by Participant Group).

Through the process of open, axial, and selective coding, codes were analyzed and clustered into themes experienced by new registrants: ***Building***, ***Bridging***, ***Being***, and ***Bettering***. The themes of ***Building***, ***Bridging***, and ***Being*** represent the three phases that new registrants experience as they progress from senior student through their first year of clinical practice. The final theme, ***Bettering***, refers to strategies that participants identified which, if implemented, could greatly benefit new registrants during the transition to clinical practice.

After identifying the four themes of ***Building, Bridging, Being,*** and ***Bettering,*** four sub-themes emerged which were embedded within each phase: ***Clinical***, ***Emotional***, ***Practical***, and ***Cultural***.

Category	Participant Groups			
	A.	B.	C.	Total
Total Participants	**6**	**5**	**2**	**13**
Age				
20-24	1	0	0	**1**
25-29	4	0	0	**4**
30-34	1	2	0	**3**
35-39	0	1	0	**1**
40-44	0	1	1	**2**
45-49	0	0	0	**0**
50-55	0	1	1	**2**
Midwifery Education Program*				
Laurentian University	1	0	-	**1**
McMaster University	4	1	-	**5**
Ryerson University	1	4	-	**5**
Community of Midwifery Practice				
Urban	4	3	1	**8**
Rural	2	2	1	**5**
Scope of Practice as a Senior Student				
Full Scope	4	3	-	**7**
Limited Scope	2	2	-	**4**
Scope of Practice as a New Registrant				
Full Scope	6	3	1**	**10**
Limited Scope	0	2	1**	**3**
Change of Scope as a New Registrant				
No Change of Scope	4	4	-	**8**
Full to Limited Scope	0	0	-	**0**
Limited to Full Scope	2	0	-	**2**
Limited to Limited Scope	0	1	-	**1**
Change of Midwifery Practice or Community				
Same MW Practice and Community	2	3	-	**5**
Different MW Practice and Community	3	1	-	**4**
Different MW Practice in Same Community	1	1	-	**2**

* The midwifery education background for participants in Group C was not collected

**These numbers represent the current scope of practice for participants in Group C

Table 2 – Demographic Data by Participant Group

This chapter will describe the key elements of the Building, Bridging, and Being theory by breaking each phase down into Clinical, Emotional, Practical, and Cultural components (Figure 2 - The Building, Bridging, Being Theory). Finally, this chapter will discuss the Bettering theme. While not part of the Building, Bridging, Being Theory, the Bettering theme represents the ideas that participants had for supporting new registrants during the transition to clinical practice. The particular suggestions in the Bettering theme will also be broken down into Clinical, Emotional, Practical, and Cultural elements.

The Clinical sub-theme includes clinical skills, managing both routine and uncommon clinical situations, and formulating and following through with care management plans. The Emotional sub-theme refers to experiences that generate emotions such as confidence, stress, fear, excitement, anticipation, anxiety, or nervousness. The Practical sub-theme encompasses systems, process, and policies that new registrants encounter, such as how new registrants are oriented to hospital policies and procedures or the particular supervision requirements of a midwifery practice or hospital. Finally, the Cultural sub-theme highlights experiences associated with the midwifery or hospital practice culture. This may include expectations surrounding on call time, issues related to work-life balance, professional relationships, power dynamics, and mentorship. The Clinical, Emotional, Practical, and Cultural themes are presented throughout each of the Building, Bridging, and Being phases and the Bettering theme.

This chapter will present the key study findings, grounded in the experiences of the participants, by describing the Building, Bridging, and Being transitional

phases, broken down into the Clinical, Emotional, Practical, and Cultural components. Finally, this chapter will discuss the ideas that participants had for Bettering, which encompasses strategies that could be implemented to better support new registrants. The Bettering theme will also be broken down into Clinical, Emotional, Practical, and Cultural elements.

BUILDING	BRIDGING	BEING
CLINICAL		
• Opportunities to practice clinical management • Exposure to various clinical situations	• Dealing independently with clinical situations • Completing supervised clinical procedures	• Confidence in clinical situations • Learn from and adapt to unfamiliar clinical situations
EMOTIONAL		
• Confidence from clinical preceptors	• Feeling the weight of clinical responsibility • Dealing with interpersonal conflict	• Freedom to develop personal practice style • Self-identity as a midwife • Professional satisfaction
PRACTICAL		
• Exposure to practical aspects of midwifery	• Navigating midwifery practice and hospital logistics • Developing time management and prioritization strategies • Adapting to call models • Coordinating business aspects of clinical practice	• Confidence in logistics
CULTURAL		
• Integration into midwifery practice • Develop interprofessional relationships	• Developing support networks – colleagues, peers, mentors • Integrating – into midwifery practice and hospital culture and broader midwifery community	• Accepted as an equal team member

Figure 2 - The Building, Bridging, Being Theory

4.1 Phases: Building, Bridging, Being

The Building, Bridging, and Being phases provide a theory to describe how a new midwife's identity evolves from that of a student into that of a registered midwife. Temporally, the Building phase generally occurs in the final year of the midwifery education program. Bridging typically begins with the initiation of the new registrant year and generally lasts for several months, and finally, Being occurs towards the end of, or possibly even following the completion of the new registrant year. This timeline depends on how long it takes new registrants to move from one phase to the next, a factor that varies greatly among individuals. For example, a new registrant may still experience feelings and display behavioural characteristics of the Building phase for several months after starting clinical practice. Similarly, while some new registrants may not reach the Being phase until the formal completion of their new registrant year, others may exhibit characteristics of the Being phase in their final year as a student or very early on in their new registrant year.

4.2 Building: Laying the Foundation for Clinical Practice

The Building phase (Figure 3) generally occurred during the final year of midwifery education when participants were taking on increasing responsibility as senior students in preparation for their upcoming role as independent

BUILDING
CLINICAL
• Opportunities to practice clinical management • Exposure to various clinical situations
EMOTIONAL
• Confidence from clinical preceptors
PRACTICAL
• Exposure to practical aspects of midwifery
CULTURAL
• Integration into midwifery practice • Develop interprofessional relationships

Figure 3 – The Building Phase

clinicians. During this final year, students are expected to take on a growing level of clinical

responsibility and, in the final months of the clerkship placement, are expected to perform all clinical responsibilities with minimal supervision from their preceptors. These responsibilities include, but are not limited to, planning and running prenatal appointments, proposing, initiating, and following through with clinical management plans, conducting vaginal deliveries, performing the role of the backup midwife at both hospital and homebirths, and initiating physician consultations appropriately. Using quotations from participants, the following section will describe the key components of the Building phase by breaking this phase down into Clinical,

Pseudonym	Age	Community of Midwifery Practice for NR Year	Change of Midwifery Practice for NR Year	Scope of Practice for NR Year	Change of Scope of Practice for NR Year
GROUP A					
BETHANY	30-34	Urban	No	Full	No
JANET	25-29	Rural	Yes	Full	No
KAREN	25-29	Urban	Yes	Full	No
LAURA	25-29	Urban	Yes	Full	Yes
SOPHIA	20-24	Urban	No	Full	No
WENDY	25-29	Rural	Yes	Full	Yes
GROUP B					
ADRIENNE	35-39	Urban	Yes	Full	No
CHARLOTTE	40-44	Urban	No	Full	No
CLAIRE	30-34	Urban	Yes	Full	No
KATIE	50-54	Rural	No	Limited	No
OLIVIA	30-34	Rural	Yes	Limited	Yes
GROUP C					
JILL	40-44	Rural	-	Full	-
MADELINE	50-54	Urban	-	Limited	-

Table 3 – Demographic Data by Pseudonym

Emotional, Practical, and Cultural sub-themes (Table 3 –Demographic Data by Pseudonym).

4.2.1 *Clinical Building*

The most pivotal element of the Building phase occurs within Clinical Building when midwifery students begin managing clinical situations independently. Karen, a participant from Group A, expressed:

> It was really helpful as a student, to have placements and practices that didn't do a lot of handholding…now as a new registrant I feel like I'm much more capable of being thrown into a situation that I haven't seen before and really logically working through what do I need to do (Karen, Group A).

While always keeping client safety at the forefront, the study participants felt that an effective preceptor during the Building phase offered a senior student the autonomy to carry out clinical care plans independently, even if those plans differed from one the preceptor themselves would make. In describing her preceptor, Sophia reported: "she was really comfortable with letting me struggle for a bit with anything. She wouldn't just jump on things" (Sophia, Group A). Having "several preceptors who were really good at sitting on their hands and watching me make terrible mistakes and letting me work it out" also gave Karen clinical independence and she felt the clinical autonomy to make mistakes as a student was "really helpful" (Karen, Group A). Overall, Karen found her experience of learning clinical management was supportive:

> I [had] preceptors who would meet me at the front door of a house and say, 'You're on your own I'm just going to stand outside and let things happen.' Not in a way that was undermining, it was definitely a supportive environment, but it was much more hands off (Karen, Group A).

In contrast, some participants were not given as much opportunity to practice clinical management. Charlotte described her experience as follows:

> At the time I thought they were backing off enough but they really weren't. I was still running the plan by them all the time and never just getting to do it (Charlotte, Group B).

Similarly, Olivia described how closely she was supervised during her time as a senior student:

> The practice that I was at had a policy that the student would only attend 50% of any prenatal visit by herself and then the preceptor would be present the second half of the visit…I mean theoretically I knew how much of my time she was spending around me, but I didn't realize how much she was helping me during that time (Olivia, Group B).

Although it is an expectation prior to graduation for midwifery students to conduct clinical tasks with minimal supervision from their preceptors, participants such as Olivia and Charlotte commenced clinical practice with very little experience managing care independently. Olivia (Group B), for example, identified: "my preceptor didn't give me as much space as I could have used to spread my wings". Olivia described how she adapted to making clinical decisions as a new registrant:

> I…kind of learned and did the experiments that I know a lot of senior year students [do], you know, the assessing someone when the preceptor doesn't think they need to be assessed, I did those things in my new registrant year rather than in my senior year. Because usually [I'd discuss] a plan with my preceptor and she would 'yea' or 'nay' it and I would call the client back and cancel the assessment or whatever (Olivia, Group B).

The experience of Olivia illustrated how, even though professionally she had moved beyond her time as a senior student, she had not yet progressed to the Clinical Bridging phase. Because of a lack of opportunity to practice clinical management as

a student, she continued to exhibit characteristics of the Clinical Building phase when she was a new registrant.

Another aspect of Clinical Building that participants described was exposure to a variety of both normal and abnormal clinical situations, including exposure to full scope midwifery practice. In reflecting on her senior year as a student, Bethany (Group A) explained, "through my final year I had a good range of abnormal [clinical situations]". She felt that the exposure to these abnormal clinical situations helped her learn "what the management plan might look like" and helped her "[not] get as anxious about variations of normal" (Bethany, Group A). As a student, Wendy (Group A) was at a limited scope practice. She explained:

> I did get a fair bit of experience from shadowing nurses for managing [inductions] as a student. So even though I didn't have full scope as a student my preceptors did make sure I did have lots of those chances so that I would feel comfortable when I graduated (Wendy, Group A).

Similar to Wendy, as a student, Olivia (Group B) was at a limited scope midwifery practice. Olivia also stated: "I had preceptors who tried to get me induction experience…If we were transferring care for an induction…my preceptor…would have me stay for the whole thing and just be supervised by the nurse". As a senior student, Laura was at a limited scope practice, but knew that the practice where she hoped to work as a new registrant practiced full scope. For this reason, Laura (Group A) explained, "I tried to tailor my placement to reflect what I wanted to do". For example, she "made a point to stay…for the epidural start…in a supportive care role" in order to take advantage of learning opportunities. The experience of Laura, Wendy, and Olivia illustrated the ways that senior students are either encouraged by

their preceptors, or take the initiative on their own, to learn from a variety of clinical scenarios, encompassing the full clinical scope of midwifery.

Emergency situations represented an important yet challenging area of clinical learning for midwifery students. Bethany (Group A) acknowledged that "everybody wishes they had more experience with emergencies"; however she also recognized that "there's not really a way you can prepare for that beyond doing emergency skills and [neonatal resuscitation]". Adrienne (Group B) also felt that obstetrical emergencies were "something that [she] had never encountered clinically but had been trained to do". Managing emergency situations was an area of clinical skills that study participants did not feel entirely prepared for upon commencing clinical practice as new registrants.

It was clear from study participants that exposure to a variety of normal and abnormal clinical situations as well as the opportunity to develop and carry out clinical management plans were fundamental components of the Clinical Building phase. As a supervisor and mentor to new registrants, Jill echoed new registrants' views and emphasized the importance of midwifery students' exposure to a wide range of clinical situations during their training:

> I think there needs to be more of an evenness in the training where everyone has to have at least some exposure…there needs to be a system, in my opinion, where there's opportunity for all students to see a bit of everything so it's not all new when they start (Jill, Group C).

The Clinical Building phase represents a time when new registrants are solidifying their confidence in clinical skills in preparation for independent clinical practice. Participants identified that having opportunities to practice clinical

management and exposure to a variety of clinical scenarios contributed to their preparation for clinical practice.

4.2.2 *Emotional Building*

As described in the previous section, one of the most formative elements of the Clinical Building phase was that midwifery students have the opportunity to practice their clinical skills as independently as possible and to learn to formulate and carry out decisions related to clinical management. Clinical preceptors have an integral role in building up the confidence of senior students by offering support and encouragement as students become progressively independent in dealing with increasingly complex clinical situations. One participant noted the impact that her preceptor had on her confidence as a senior student:

> She probably gave me the most confidence ever just because she'd seen the difference, she'd seen the progress, and she had faith in me, which made me have faith in me so that helped a lot (Laura, Group A).

Midwifery preceptors had the opportunity to support new registrants as they moved through the Emotional Building phase. Participants expressed how having a positive relationship with their preceptors and receiving positive encouragement during the senior year fostered feelings of self-confidence:

> In my clerkship placement my preceptors were really good at trying to advocate for me to get to births and things, so they were like, 'She's almost a midwife. She's only months away, weeks away, days away.' And they were counting down with me, and so they actually probably got me more pumped than I would have been on my own (Laura, Group A).

Another participant also expressed: "I loved it [at my senior placement]. I don't think I've ever felt more stable as a person" (Janet, Group A).

In contrast to this, one participant described how not being given the chance to manage a clinical situation negatively impacted her clinical confidence:

> I had two preceptors that were kind of at different ends of the spectrum. One who was…just more eager to jump on things…and that really became tough as a student. It gets discouraging when you're like, 'Am I not capable of doing this?' And then afterwards she'd say to me, 'Oh I'm really sorry I jumped on that, I probably could have let you do it.' But, like, well 'Probably could have?' or 'Could have?' Would I have been able to do it? (Sophia, Group A)

Another participant, who described her preceptor as a "helicopter parent" stated:

> I don't think I gained as much confidence in clinic as I think some of my colleagues did at their student placements, because my preceptor was kind of always there making the final decisions sometimes before I'd had enough time to give the client my thoughts. (Olivia, Group B)

Participants recognized the impact that preceptor-student relationships have on the senior student experience. When the relationship with the preceptor was challenging or negative, or when the relationship involved unresolved conflict, this negatively affected the midwifery students' confidence. One participant described her difficult student placement:

> I had a student placement that I transferred out of voluntarily because I had a very poor relationship with my preceptor…I had to figure out how to manage that, and how to manage that process of advocating for myself (Karen, Group A).

While participants from Group A illustrated the positive and negative impact a student's clinical preceptor may have during the Emotional Building phase, one participant from Group C described the connection between midwifery students' confidence in managing clinical scenarios and their ability to transition to clinical practice: "If they are a confident clerk and able to step into that primary role smoothly, really that new registrant year is much smoother" (Madeline, Group C).

Confidence was the emotion that participants indicate was most pivotal during the Building phase. The confidence that participants experienced during this phase was associated with both the relationships that students had with their clinical preceptors, and confidence seemed to improve when clinical preceptors were able to step back and allow the student space to practice independently.

4.2.3 *Practical Building*

The Practical Building phase provided participants with the opportunity to experience the practical aspects of midwifery, including learning the intricacies of urban or rural practice, working in a large or small midwifery practice group, and working in either full scope or limited scope communities. The location, scope, and model of care that midwifery students experienced during the final year of education influenced how they viewed and practiced midwifery in their new registrant year.

As a student, one participant identified the impact that call schedule had on her student experience:

> As a student my first two placements were…at a shared call practice, which was really really challenging…and then my clerkship was at a primary call practice…and that was fantastic (Karen, Group A).

Another participant felt that it was important for students to have "a mix of experiences because then you can go anywhere" (Bethany, Group A). Because clinical placements are determined by lottery, it can be difficult for students to obtain the exposure to the breadth of clinical experiences and various midwifery practice characteristics they desire. One participant described this dilemma:

> [There are] postings for rural areas that sound really great but I don't have any rural experience and I tried to coordinate it so that my normal

> childbearing placement was rural, but then I lost that placement when I got shuffled (Bethany, Group A).

During the Practical Building phase, midwifery students experienced various practical aspects of midwifery practice including call schedule, scope of practice, and urban or rural community. A midwifery students' exposure to the various elements of midwifery care impacted that individuals feelings of preparedness to practice midwifery within a defined midwifery context.

4.2.4 *Cultural Building*

The final component of the Building phase is Cultural Building. This phase involved midwifery students becoming familiar with the culture of midwifery within the midwifery practice, hospital, and wider community. During this time, midwifery clerks actively participated in the daily functioning of the midwifery practice and, ideally, were treated and saw themselves as meaningful members of the team. One participant described her experience as a midwifery clerk as follows:

> I felt part of the team; I felt like it was a professional practice. I felt like people knew what they were doing in terms of the business side of things, and in terms of the midwife side of things (Janet, Group A).

This participant also described how the supportive culture at her midwifery practice had a positive impact on her experience as a student:

> I think I was very lucky in that my senior placement was with people, at a practice where people really had their things under control, so I felt as confident as you can feel in that role… I managed to find a good balance between my other life and still the crazy on call, and being-a-student life (Janet, Group A).

In addition to experiencing the culture of the midwifery practice, individuals in the Cultural Building phase were exposed to the midwifery in the context of the

hospital and the wider community. This exposure involved both becoming familiar with hospital and community standards and developing interprofessional relationships. One participant described her experience with integration into the obstetrical community:

> You know what the community expectations are and what the community standards are…sometime people recognize you and know who you are (Bethany, Group A).

Another participant described her experience developing interprofessional relationships within her community during the Building phase:

> Even as a student I really made an effort to try and get to know as many names as I could and really, and even just [acknowledging] the nurses…and [saying], 'Ok, you guys really helped me this semester. Thank you' (Sophia, Group A).

Participants described their integration into both the midwifery practice and hospital community as elements of the Cultural Building phase. Within a midwifery practice, this integration involved the midwifery practice team's authentic recognition that midwifery students were important to the team, especially as the students took on increasing independence and responsibility. In the hospital community, students built interprofessional relationships and developed the professional communication and interpersonal skills that are essential as a practicing midwife.

4.2.5 *Building Summary*

The Building phase was a time of preparation for the Clinical, Emotional, Practical, and Cultural elements of independent clinical practice. The key factors of this phase included: opportunities to practice clinical management; exposure to a variety of clinical situations; confidence from clinical preceptors; experience with a

variety of call schedules, scopes of practice, and communities; integration into the midwifery practice team; and development of interprofessional relationships. While many participants experienced the various elements of the Building phase during the final portion of their midwifery education, if participants were not afforded adequate autonomy as a student, they continued to experience elements of this phase once they commenced clinical practice.

4.3 Bridging: A Roller Coaster Ride

The Bridging phase (Figure 4) typically occurred once midwifery students had graduated and were practicing as new registrants. During this phase, participants described how they experienced true independent clinical practice for the first time and fully took on the professional responsibilities of a registered midwife without the supervision of a clinical preceptor. This phase was characterized by dichotomous feelings of satisfaction for one's career choice, and feelings of fear and vulnerability. During this phase, participants struggled with balancing the multitude of clinical tasks and responsibilities and navigating the logistics of their midwifery practice and hospital.

Figure 4 – The Bridging Phase

The mentorship that participants received and the support networks that they built during this phase were highly influential in their overall experience of the Bridging phase.

4.3.1 *Clinical Bridging*

As elaborated in the Clinical Building phase, the opportunity to practice clinical management as a student laid the foundation for independent clinical practice. Even participants who were given ample opportunity to manage clinical care as students, noticed the absence of their clinical preceptor once they began practicing as a new registrant. Laura summarized one of the most common sentiments expressed by participants when she said:

> It's definitely a bit scary thinking about being in the hospital on my own. Because as confident as I feel, having someone else there, they are a safety net, and [I don't have] that safety net anymore (Laura, Group A).

Another participant, Charlotte, also noted the absence of a clinical preceptor to review clinical management plans:

> When you get out there as a [new registrant] there's no one to run the plan by. You have to have the confidence to go to the next step and just do it. You made the right decision (Charlotte, Group B).

One participant described her experience of having difficulty determining what decision to make:

> I think when it does come to being the person who ultimately makes that call there's that sort of paralysis of analysis where you're like, 'Oh my god, [there are] ten different things I could do here,' and trying to think about each one and which one is best and maybe there isn't a best; maybe I just have to do something reasonable and see how it unfolds (Laura, Group A).

These quotations illustrated the common experience of the Clinical Bridging phase where participants no longer had the "safety net" of a clinical preceptor that they did during the Building phase. Participants were acutely aware that in the Bridging phase they were now the ones taking on the responsibility for clinical decisions.

Emergencies represented an area of clinical care that were particularly difficult for new registrants to manage due to the high-stakes and unpredictable nature of these situations. While some new registrants had experienced dealing with emergencies during the Building Phase, many had only participated in emergencies as observers or through emergency skills training workshops. One participant described a particularly difficult emergency situation she encountered early on as a new registrant:

> Throughout school I never once had a homebirth transfer. And then my first three homebirths as a new registrant were transfers…my very first one was an emergency one for cord presentation…So that was scary. And the scary part too was that I had called for supervision and the person who was going to supervise me wasn't available so they called another midwife to come but she was delayed…I actually had to call 9-1-1 for my first time ever (Bethany, Group A).

Despite having limited exposure to emergency obstetrical situations, some participants were surprised to discover that their training had prepared them to deal with these situations. One participant described her experience as follows:

> The first few times I had wonky stuff come up…I was like, Ok, no, I need to take a breath, I know what to do…I think it's one of those things where you realize you're already riding the bicycle without realizing that you're doing it…you suddenly realize how you're on autopilot and you're already doing things before you even think, ok, what was my first step, well you're already on step three (Sophia, Group A).

Another participant reflected on how she managed an emergency situation:

> I really felt like that training just poured out of me, and the things that I was trained to do, I just did them. And I did them efficiently…so I felt very pleased about that… So just to be able to use the different aspects of my training and put them together…So that was really good (Adrienne, Group B).

Managing obstetrical emergencies was challenge of the Bridging phase that participants identified. While emergency situations were inherently stressful to deal with, reflecting on their own management of these scenarios actually provided participants with some validation of their clinical skills and confidence in their ability to deal with emergencies.

Another aspect of Clinical Bridging that participants identified was the clinical supervision that new registrants received. Many midwifery practices and hospitals have set requirements with respect to the direct supervision of new registrants for particular clinical situations such as hospital births, homebirths, triage assessments, clinic visits, managing epidural analgesia, and conducting oxytocin augmentation or inductions. Participants were often required to have a set number of these procedures supervised by another registered midwife before being permitted to conduct these procedures independently. For one participant "there [were] requirements when you start working at the hospital you [had] to do five supervised births before you're able to do births on your own" (Karen, Group A). Another participant explained: "I had to manage ten oxytocin inductions before I could do one on my own" (Olivia, Group B). An experienced midwife described how her community had a set number of required procedures but also how the length of supervision was guided by the new registrant's learning needs.

> We also have full scope at our hospital, and it is a requirement that we have someone to provide that new person for a minimum of five epidurals and five oxytocin inductions. So we have a fairly high rate of epidurals, but also we have to be there the whole time, so that is long…The new registrant I had a few years ago…didn't need nearly as much compared to this new person, but again everyone works at different rates (Jill, Group C).

In contrast to midwifery practices that required a specified number of supervised births and clinical procedures, other participants described a more flexible approach to clinical supervision. One participant explained:

> I think because I had my mentor as my preceptor already and because I'd been in full scope and managed epidurals and things like that…my first few births it was more so, kind of like an informal, 'Call me whenever you need me, as soon as you need me'…We never sat down and formally decided, 'Okay, you'll watch me do this many births or this many epidurals' (Sophia, Group B).

Since one of the biggest challenges that new registrants faced in the Bridging phase was the absence of the safety net of a clinical preceptor, many participants appreciated when there were a specified number of supervised births at the beginning of their new registrant year. This was best described by one participant who stated:

> It was absolutely critical to have someone with me for a few births. I don't think six was a magic number, per se, but for a handful of births it was definitely useful and it was nice to feel like I wasn't asking someone a favor by asking them questions or getting oriented. I knew that it was just the expectation that they would be there with me, so that was nice (Adrienne, Group B).

Despite the sense of security that some participants felt by having another midwife available to supervise the first few deliveries, another participant described how she had difficulty asking this supervision of her colleagues:

> Basically…every time one of my clients needed an induction, I [needed] to have a more senior midwife there with me from beginning to end of

> the induction…It was very difficult for me to ask that of them, and so it definitely affected how I was managing some of my clients…because I didn't want to burden my colleagues (Olivia, Group B).

The results of this study showed that the supervision that participants received during their new registrant year was highly variable. Sometimes supervision numbers were dictated by hospital or midwifery practice protocols, and other times supervision numbers were determined exclusively by the self-reported clinical learning needs of the new registrant. Regardless of how supervision numbers were determined, the findings suggested that having some supervision for clinical procedures including triage assessments, births, epidural management, and oxytocin augmentation and induction, were beneficial for new registrants during the clinical bridging phase.

For routine, complex, and emergent clinical situations, participants noticed the absence of their clinical preceptor as they began to make clinical decisions independently during the Bridging phase. Even participants with adequate experience practicing clinical management during the Building phase noticed this change. Participants also identified that it was helpful when there were clear guidelines set either by the hospital or by the midwifery practice with respect to when they were required to call a more experienced midwife for supervision in particular clinical situations.

4.3.2 *Emotional Bridging*

Interview participants commonly described the experience of Emotional Bridging as a series of highs and lows. One participant compared the transition to clinical practice to being on a roller coaster.

> It's kind of been a roller coaster, I'd say. Some days it feels pretty overwhelming and scary and terrifying, like 'Why did I do this? I thought it was supposed to get better and then it feels like it's not'. And then other times I do feel very well supported at my practice and like, 'Ok, I can do this, it'll get better.'…So it's up and down. It's very up and down (Wendy, Group A).

The high points of this rollercoaster were demonstrated particularly well by one participant who said:

> Graduating actually provided me with a lot of freedom and space to actually have my own ideas without feeling the pressure of needing to perform for someone. I felt like I could actually be myself (Adrienne, Group B).

The low points of this emotional rollercoaster occurred when new registrants realized the true weight of responsibility they had in caring for clients. One participant was particularly surprised by the weight of responsibility she felt with clinical practice and reflected:

> I guess the biggest shock for me was, just, the feeling of responsibility that you have suddenly when you're the midwife…You don't really feel that as much as a student even though you're still managing things as a student…you still have to go over it with your preceptor. As a new registrant, that layer is gone. So that was surprising to me (Wendy, Group A).

Fear of missing something, feelings of inexperience and vulnerability, and regret or anger when looking back on particularly difficult clinical situations were common sentiments during Emotional Bridging. One participant expressed:

> I had significant fear of missing something. I don't want to miss something. I take this job very seriously; I think that we hold a lot of responsibility (Janet, Group A).

For some participants, these challenging emotions manifested in physical symptoms, such as insomnia, while others experienced mental stress with questioning management decisions and re-living clinical scenarios. As with Wendy and Janet's

above reflections, Olivia described how she felt unprepared for the weight of responsibility she grappled with as a new registrant:

> I think more than anything, the only thing that I didn't already know about or feel prepared for was how deep the feeling of responsibility would become for me. So I lost a lot of sleep, tossing and turning, debating the management decisions at the labour I had just come home from and those kind of things that I never did as a student…Once I became a new registrant it took a lot of strategizing for me to figure out how to deal with insomnia because every single time I came home from a birth, I would keep managing the birth in my sleep. So I think that's the only thing that I really didn't feel prepared for, but I don't even know if there's any way that the program could prepare you (Olivia, Group B).

Stress and anxiety related to the weight of clinical responsibility was a common theme for participants in the Emotional Bridging phase. These feelings were linked to the recognition that there was no longer the safety net of a preceptor to depend on and graduates instead were required to rely on their own clinical competence.

Another significant emotional challenge for participants occurred when they encountered personality conflicts with their midwifery colleagues. These conflicts were particularly significant because they were unanticipated by new registrants. In reference to a personality conflict with a colleague, one interview participant expressed that the stress associated with this conflict was much greater than the weight of responsibility associated with clinical practice. She described her experience as follows:

> I thought that the responsibility would be more stressful. And in the beginning it is and it was…but as I'm getting more confident and more comfortable with the clinical side, the other side hasn't changed, [the personality conflict is] still there. So that continues to be more stressful (Bethany, Group A).

Janet (Group A) described her extreme difficulty connecting with and relating to her assigned mentor: "They were mentoring me, but it was a poor fit. Maybe it's a fit for

someone who is a more strong-willed personality, I don't know, but that's not me." The above quotations from Bethany and Janet illustrate how the interpersonal relationships that new registrants encounter during the Emotional Bridging phase can impact the overall experience of transitioning to clinical practice. As new registrants, individuals no longer had the emotional support of a clinical preceptor or tutor to mediate interprofessional relationships; instead new registrants had to independently manage challenging interpersonal situations in a professional and collegial way.

The key emotional challenges that were faced by new registrants during the Emotional Bridging phases included adapting to the weight of clinical responsibility and managing interpersonal conflict. Although midwives are likely to encounter emotional challenges related to clinical responsibility and interpersonal conflict throughout their careers, druring the Bridging phase these challenges seemed more acute as new registrants experienced them for the first time. While the freedom to experience clinical autonomy was empowering for new registrants, the burden of difficult emotional situations was correspondingly defeating.

4.3.3 *Practical Bridging*

Challenges in navigating the logistics related to their midwifery clinic and hospitals characterized the Practical Bridging phase. For many new registrants, the multitude of logistic and organizational tasks associated with clinical work was just as demanding as managing complicated clinical situations. The logistics of midwifery practice included: coordinating the day-to-day responsibilities of managing a caseload, running a clinic, managing paperwork, and prioritizing tasks; keeping track

of policies and protocols related to work within the hospital; adapting to the midwifery practice call schedule; undertaking the process of joining and registering with professional associations and obtaining hospital privileges; and finally, understanding the financial aspect of midwifery, including fees and billing.

With respect to coordinating and prioritizing the multitude of clinical and administrative tasks associated with day-to-day midwifery practice, one participant identified logistics as "the hardest part" (Bethany, Group A) of her transition to clinical practice. Another participant who found understanding the logistics at the hospitals particularly stressful offered this description:

> There was definitely a lot of anxiety for me about having to go into the hospital and somehow manage to get it done. I think I had this sense that the hospital was this big, dark, void where all this paperwork had to happen and all these steps had to take place, and I think there was a lot of panic at the idea of going into the hospital with clients…And that was a hard transition, actually going in and physically doing all the paperwork, and making the calls, and doing the consults, and getting things started, and having it all happen, not in 10-hours, but in an hour. So that was a big learning curve, but it feels so much better now that I've had to do it four or five times, and I think after the third time and I was like, 'Okay, I can do this, it's not that bad' (Karen, Group A).

Participants described strategies that they used to address challenges related to logistics as they transitioned through the Practical Bridging phase. One participant explained her struggle with organizing clinic paperwork:

> I'm trying to figure out…how best to keep track of ultrasounds…having a system in place where you know when your client's going for an ultrasound so you can follow up on it instead of just waiting for it to come through the [mailbox] (Bethany, Group A).

Another participant struggled with time management during her clinic days and described how she adapted to this challenge:

> I made sure to have very long clinic appointments for the first little while. I actually still prefer longer appointment over the shorter ones, in order to give myself time to gather information at my own pace (Olivia, Group B).

During the Practical Bridging phase it was necessary for new registrants to develop organizational, time management, and prioritization strategies to manage the multitude of tasks and responsibilities associated with clinical practice. Developing these skills and strategies demonstrated an ability to cope with the increased organizational demands of clinical work.

Many participants felt that having previous experience as a student in the community where they completed their new registrant year was a "real advantage" for Practical Bridging (Katie, Group B). Katie went on to describe this "advantage" in more detail:

> I had the opportunity to become acquainted with the practice [and] with the hospital. I'd also done several of my interdisciplinary placements at the same hospital, so for me that's a huge win…I certainly feel that it would be much more difficult to navigate the new registrant year if, on top of, 'Oh my gosh, they now expect me to do this for real'…I had to negotiate a new hospital, and a new practice, and all the things that come along with that…I certainly feel that's an advantage in terms of navigating your new registrant year (Katie, Group B).

Sophia was one of two new registrants at her midwifery practice. In comparison to the other new registrant who had changed communities and practices after graduation, Sophia perceived her transition to clinical practice to be easier; she explained:

> I found the transition was smooth…we have another new registrant at the clinic who was at another clinic previously and I can see where I feel really confident with little things, even just knowing where things are in the clinic, how easy that transition was for me opposed to me her coming from a different clinic (Sophia, Group A).

In contrast to participants who identified a benefit from having previous experience at the same midwifery practice and hospital, other participants did not necessarily feel that this previous experience was advantageous. One participant found it particularly difficult to negotiate the hospital logistics, even though she had been a student at the practice where she was completing her new registrant year. She explained:

> Even being a student here, it's still [difficult] because you always had someone who you could be like, 'Okay I'm going to call this person then I'm going to do this thing'…Because say you have an ultrasound that comes back with [polyhydramnios], is it something that I need to call the OB on call for? Can I send a consult note to somebody's office? And then everyone's different too in terms of what they want to do. Should I bring them in for a [non-stress test]? Or can I send them to the floor? I find all of those small things, those small little details, are the things that become the most stressful cause you get the result and then you're like, 'What do I do? I know I need to do something, but what's the proper procedure?' (Bethany, Group A).

This quotation was particularly interesting as it illustrated that, even new registrants who did not change midwifery practices or communities for their new registrant year had difficulty familiarizing themselves with the practical aspects of clinical care. While a midwifery practice or a hospital may be familiar from a previous clinical placement, with the additional responsibilities of independent clinical practice there are Practical elements that all new registrants must make sense of during the Bridging phase, regardless of their previous clinical experience.

Within a midwifery practice group, expectations surrounding call scheduling were a central Practical component since a midwifery practice's call schedule impacts on call and off call time, caseload, vacation, call coverage, relief, and ultimately, work-life balance. There are various call models that midwifery practice may adopt that provide on call coverage and continuity of care for clients and also

enable midwives to take adequate time off call to support work-life balance. Ideally, call schedules are mapped out equitably, include regular off call time for weekends and vacation, and have clear guidelines for accessing relief following extended periods of being awake. One participant explained that new registrants at her practice received an orientation package which included information about "how the clinic schedule works, how the on and off call schedule works" (Madeline, Group C). In contrast to this clear direction, one participant explained that:

> It was just really hard for me to jump into a place that didn't seem to have any of their ducks in a row…it's hard enough being a new registrant and it's hard enough to be at a new practice. And then being at a practice that doesn't have any idea how to handle [their call schedule]…they didn't have a call schedule; they had nothing (Janet, Group A).

Some midwifery practice call schedules were extremely complicated, or the practice culture was such that midwives felt pressure to stay on call despite scheduled time off. One participant experienced some tension when trying to schedule her off call time, while considering the Cultural expectations of her midwifery practice:

> There is an expectation because we work primary care in a medium sized practice…that you organize your days off to correspond with due dates of people… if all my due dates for the month for some reason are at the start of the month, they're wanting us to try to book your days off at the end of the month because then you won't be missing your due dates. But then someone goes twelve days late, you're like, well it's my vacation day now. So other midwives are always disappointed when that happens, but they understand, especially if you've booked travel tickets or it's a family birthday party or something. So there is that pressure (Adrienne, Group B).

One participant explained that she preferred working in a primary call model because of the benefits she experienced related to work-life balance and with respect to the relationships she built with her clients. She explained:

> I would prefer to do primary call if given the choice. I find that there is much better work-life balance for me. I find that when you're doing shared call you spend a good chunk of your time doing handover and a lot of it is communication with your partner midwife, not with your clients. Also I like having a client list that I know…when someone pages me I know who they are, and I don't have to get a whole background history. It alleviates a lot of the stress when I'm living with a pager…its pretty easy to just live my life and do the things that I want to do (Karen, Group A).

In shared call models, midwives work closely with one or more midwives in a team. Some participants preferred shared call models because, in sharing client care responsibilities with a team, they felt reassured that other midwives were reviewing client care over the course of the pregnancy. This participant described why she preferred shared call, especially at the beginning of her new registrant year:

> Starting out [in shared call] was really beneficial because I knew that there was a second set of eyes looking over what I was doing. Apart from the supervision you have at births, there was a second set of eyes looking out for the chart, making sure I don't miss anything or ordering things. So that does provide some comfort as well…it's different than having a preceptor checking off everything you're doing but you're still having a little bit of a safety net in place (Bethany, Group A).

Although some participants cited a preference for one call model over another, there was no clear call model that seemed best for new registrants. It was clear, however, that during the Practical Bridging phase, participants appreciated when call models were well organized and when there were clear guidelines surrounding off call time. During the Practical Bridging phase, new registrants participated in the call schedule of the midwifery practice for the first time. Amidst adapting to the various logistical and organizational components of clinical practice, having clear guidelines with respect to the call schedule within the midwifery practice enabled participants to understand where they fit into the overall call model of the midwifery practice.

The process of becoming registered with College of Midwives of Ontario (CMO), of becoming a member of the Association of Ontario Midwives (AOM), and of obtaining hospital privileges were aspects of Practical Bridging that all new registrants had to work through. In referring to her confusion about registration and membership with midwifery professional organizations, one participant joked that she felt "like the AOM and the CMO [were] sort of like secret societies" (Laura, Group A). One participant expressed difficulty in figuring out the timing, documentation requirements, and fees associated with the CMO, the AOM, and the Canadian Midwifery Registration Examination (CMRE):

> I think a big stressful part for me that I didn't really know about going into it was the financial side of things as a new registrant. That once you graduate you have to pay for the CMRE, you have to pay for the AOM fees and college fees and for when you start…so I know me and my classmates we were all al little surprised at the amount of the fees and that we have to pay them all before we're even making money. That's challenging, a challenge we weren't anticipating (Wendy, Group A).

Obtaining hospital privileges can be a slow process, taking weeks to months following registration with the CMO. This timeline presented difficulties for midwifery practices that choose to book caseload for new registrants in anticipation of registration and hospital privileging, without being certain of how long these process would take. One participant described the impact of her delayed hospital privileges:

> The trouble was that I didn't have hospital privileges so…six of my clients had already delivered by the time I got funding, so I lost a lot of income opportunity there. But I didn't have hospital privileges so I had to just take their pages and send another midwife to go and catch their baby (Olivia, Group B).

This uncertain timeline was difficult for new registrants because they may be conducting clinic visits for months before attending births in the hospital. New

registrants also experienced financial stress since midwives submit billings and receive compensation only after discharging clients from care, typically at six-weeks postpartum. Some midwifery practices were able to offer financial assistance to new registrants in the form of an advance on pay to help bridge the gap between when a new registrant is hired and when that individual is able to submit the first billings; however, not all practices were willing or financially able to do this, and for some participants, even an advance did little to ease the financial strain of several unpaid months of work. Sophia explained what she did to handle this challenge: "I picked up a part time job in between graduating and starting because I didn't know when I'd be working" (Sophia, Group A). One interview participant outlined very well many of the financial barriers she faced as a student and how she did not feel adequately prepared for this reality:

> I think the impression was given that you finish school and then you find a job and it's great and you get paid. And suddenly we're all graduating and we're realizing that, actually, it's very possible that we're not going to get paid, and it's possible that we're going to have to take out a loan for another year… Maybe the job you really want, in the community you really want, doesn't have the availability of funds to pay you right away. And you may have to say no to that job, or you may have to say yes to that job and take on additional debt in order to make it work (Karen, Group A).

One participant also drew attention to her limited understanding of how midwives were paid when she stated: "It's really grey when you graduate when you're going to get paid, and how exactly you'll get paid, and how much it will be" (Sophia, Group A). Participants experienced budgeting for professional fees, understanding the timeline between graduation and getting paid, and learning the process of submitting billings

for the first time during the Practical Bridging phase and identified several challenges related to these financial aspects of professional practice.

During the Practical Bridging phase, new registrants learned clinic and hospital logistics, developed organizational, time management, and prioritization strategies, adapted to their midwifery practice's call model, organized the various adminstrative requirements of registration with the CMO, AOM, and their hospital's priviledging process, and learned about billings and finances. There was a prevalent assumption that new registrants who were able to complete their new registrant year at the same practice where they were a senior student had a significant advantage over new reigstrants who had to change practices; however, in some instances this assumption was false given the multitude of new logistical tasks that all new registrants were required to take on, regardless of where they were a senior student.

4.3.4 *Cultural Bridging*

The final area of the Bridging phase is Cultural Bridging, wherein new registrants learned and adapted to the relationships and expectations both within their midwifery practice group and in the wider hospital and community. Cultural Bridging encompassed issues related to developing support networks, integrating into the midwifery practice and hospital culture, and understanding group and power dynamics.

During the bridging phase, participants accessed support from various sources including friends, family, peers, and colleagues. Several participants explained that other new registrants were a source of support. Laura described how

it was helpful to have another new registrant at the same midwifery practice where she was working:

> Having [another NR] here and knowing her ahead of time [was] helpful…Especially since she did her last placement at this practice. So if she knew where things were and I didn't feel silly asking her more logistical things…where the speculums are and stuff like that. I guess that helped a little bit knowing that I wasn't the only little fish (Laura, Group A).

Other participants, such as Karen, found support from midwives who had recently been new registrants themselves:

> The midwife who was a new registrant at the practice last year has been a huge support. And I think that's mostly because she put herself out there as a support, she made it really clear that she wanted to be a support for someone coming in (Karen, Group A).

Finally, some participants explained how the peer relationships they had formed as students developed into supportive collegial relationships, even when their new registrant peers were not at the same midwifery practice. Olivia described this experience best when she said:

> There was a senior student in my senior student year who was a new registrant at the same time as me…we [lived] far away from each other, but we would bounce a lot of stuff off of each other, especially in our first maybe three or four months (Olivia, Group B).

During the Cultural Bridging phase new registrants no longer had the inherent support of midwifery student peers, clinical preceptors, or tutors. As such, many participants found support from other new registrant peers. As illustrated in the quotes from Laura, Karen, and Olivia, this support came from current or recent new registrants within one's own midwifery practice, or from new registrant peers at other midwifery practices.

The other common source of support that participants identified was mentorship from experienced midwives at their practice. Although most participants explained that they entered their new registrant year with the expectation that they would be mentored, the mentorship that participants actually received was highly dependent on how their midwifery practice had organized its new registrant mentorship program. One participant described how her midwifery practice had a very organized program of orientation and support:

> At our practice it was laid out in the interview process that mentorship was an expectation that new registrants could have coming in. One midwife volunteers to be an assigned mentor of the new registrant, and that midwife makes herself available, basically at all times, if the new registrant has questions or need support or wants to review cases or anything really. And in addition to being available, that mentor regularly checks in, either by phone or in person, just to say, 'Hey how are things going? How are you feeling about everything?' Or if there's been a birth that the midwives are aware of that's happened that mentor will call and check in to say, 'How did you feel about that? Are you doing okay? It sounds like that was a difficult birth' (Karen, Group A).

While the mentorship model described above offered structured support for new registrants, this type of organized mentorship was not common among the study participants. Many participants explained that, while their midwifery practices did assign a mentor midwife to each new registrant, the mentor midwife did not actually provide mentorship to new registrants; in some cases the participant was not even aware of which mentor was assigned to them. One participant explained:

> I wasn't actually assigned a mentor, so that was challenging because I didn't have one specific person who I could go to with my questions. I'm sure on paper they probably put one of them down as a mentor but in reality they never told me who that person was (Olivia, Group B).

In these situations, participants relied on the support of various midwives at the practice based on factors such as convenience, approachability, and previous

interactions. This participant described how, when her assigned mentor did not seem receptive to her concerns, she found support from other midwives within her midwifery practice:

> If I ever had a clinical question in the moment I usually called one of the midwives on our team. I did call my mentor a few times, but she's very brusque and difficult to talk to and not very welcoming to questions, so I would often call another midwife who was on the floor, or who happened to be working in the hospital on the same day if I was in the hospital, just like, have a hallway conversation with them. Or call another midwife that I knew was on call from our team and just chat with her. If it was something afterwards, like I felt like I needed to debrief about it, I would often just debrief with one of the other midwives in our clinic (Adrienne, Group B).

Even when participants were aware of their assigned mentor, barriers prevented the new registrant from calling the mentor, or other colleagues, for support. For some participants, the assigned mentor was a poor fit because of either professional or personal reasons. Adrienne (Group B) described her mentor as being: "closed and difficult to communicate with"; this influenced her ability at access the support of her mentor:

> [My mentor] also has a bunch of additional responsibilities outside of being a midwife, like, she has administrative responsibilities and is just a little bit overworked, so…I feel like when I do ask her questions, my questions are not well received. But when I ask some of the other midwives, they're very open to being helpful. Even if I know they're busy, they're happy to spend the time to help (Adrienne, Group B).

Some participants found that they were able to go to other midwives within their pratice for help when they felt that their assigned mentor was not a good fit. One participant said:

> Technically I did have someone assigned to me. Apparently my partner was assigned to all the new registrants. But…naturally you're going to discuss things with some people more than others. There's some midwives that I pretty much never have done any births with just cause

> they're in a different call rotation I barely see them, I often don't discuss anything with them. Whereas there are midwives you see more frequently. I try not to ask my former preceptors for a lot cause I feel like they've done that already and I should move on (Bethany, Group A).

One participant described a situation where, although she had an assigned mentor, she was unable to contact this midwife, or any other midwife from her practice, even when she was actively seeking support:

> I find that in some ways the mentorship isn't always great, and I don't know if it's because I'm used to having a preceptor with me all the time, but I just feel like they're not as available to me as maybe I would hope…I was at a home visit once, and there was weird stuff happening, and I didn't really know what to do, and I couldn't get a hold of my mentor to kind of hash out a plan. So I ended up calling my preceptor from the previous year, and she helped me out, but like, this probably isn't a situation I should be in. So there have been a couple situations like that…I feel like maybe the expectations of mentorship…need to be talked about more (Wendy, Group A).

The above quotations demonstrated how new registrants may not access the support of a mentor, but seek support elsewhere when needed. Although many participants expressed having expectations of mentorship going into their new registrant year, having a mentor specifically assigned to them did not necessarily translate into adequate mentorship, particularly in situations when the assigned mentor was unavailable or was perceived as unapproachable. In the Cultural Bridging phase, participants sought support elsewhere when the mentorship fell short of their needs and expectations.

The main benefit identified by participants who experienced positive mentor relationships was how their mentors were able to help new registrants work through the complex emotions related to difficult clinical situations. Following her experience at an obstetrical emergency, one participant explained:

> I went to the clinic afterwards and debriefed with my mentor that day; we went out for dinner and talked it through and did a peer review the following week (Sophia, Group A).

Another participant explained how her mentor helped her process clinical situations:

> Ultimately she helped me be more philosophical about the things that I can control and the things that I couldn't…definitely within the practice there was always the opportunity to say, 'What if I had done this?' or 'Should I have called her active then?' So definitely within our practice that's always been very safe to do (Katie, Group B).

In exploring the mentorship experiences of study participants, it became clear that formal mentorship was something that participants expected during the Cultural Bridging phase, however the quality of mentorship varied significantly among participants. This translated into some participants feeling very well supported during their transition to clinical practice, and others feeling "surprised" (Claire, Group B) and "isolated and very annoyed" (Adrienne, Group B) when they did not receive the mentorship that they expected. The ability for participants to access effective mentorship influenced their overall adjustment to independent clinical practice across many aspects of the Bridging phase, and thus was a critical factor in the Cultural Bridging phase.

While mentorship from individual midwives was pivotal in the adjustment to clinical practice, the overall culture of a midwifery practice contributed to participants feeling supported during their transition to clinical practice. One participant reflected on her own experience with mentorship during her new registrant year: "I wasn't assigned a mentor specifically, but…there was always someone on call who I could [go to]…but I didn't specifically have a mentor" (Claire, Group C). Another participant described feeling like she was part of a team at a very supportive midwifery practice:

> I'm actually really appreciating the collaborative team approach. That's what it really feels like to me, it doesn't feel like hand-holding, it feels like there's this team of midwives who I can work with whenever I need to, so I don't really ever feel like I'm making a decision completely on my own. I feel like I can consult with whoever I need to make sure either I'm following the protocols correctly, or that I have someone who's more experienced giving me an opinion to help me make a decision. So I actually really like it a lot (Karen, Group A).

Adrienne's experience, on the other hand, illustrated that a supportive practice culture was not universal:

> It feels like you can't ask a lot of questions; that people are all very hurried. There's this dual message of, 'Of course, ask me questions any time,' but also, 'I'm hurried, please don't bother me' (Adrienne, Group B).

One participant from Group C explained how she felt that her own practice fostered a culture of support for the new registrants who they hired:

> We've tried to create a culture in our practice [where]…you don't have to get as close as you can without going over when it comes to attending at a birth. It's okay if you call people earlier; if you need the support then it's okay. We feel that that's safe practice; to make sure that we don't have a stressed or frightened or overtaxed or overtired new registrant trying to work because she has something to prove…We all do it for each other and it's ok for her to do it too. So call if she has questions, call, if she feels that she's in over her head, call, if she feels like, 'Well, I'm not quite sure'…err on the side of calling us sooner…[We try] to create the environment where it's okay to ask for help (Madeline, Group C).

The midwifery practice culture, overall, had the ability to support new registrants in their transition to clinical practice. Although individual midwifery mentors were important, participants felt most supported when their colleagues expressed an overall willingness to help when necessary. This intraprofessional support was valuable to participants during the Cultural Bridging phase as participants build professional networks of support.

As described in the Practical Bridging section, some participants suggested that new registrants working in a midwifery practice where they had previously been a student had an easier time adjusting to clinical practice. One participant noted about another new registrant at her practice who had previously been a student there:

> Her integration into the practice has been seamless. They're basically treating her like an experienced midwife, not like a new registrant because she already was supervised for her whole senior year here so they know her very well and they've made her what she is (Adrienne, Group B).

While this "seamless" integration into a midwifery practice may seem favorable, for another participant, this actually presented a challenge with respect to the level of mentorship she received as a new registrant:

> There was nothing like [mentorship]…I wish there had been. I think because I was a student there for the year they were quite confident in my skills and they had seen me work so they didn't have any concerns. But as you know it's quite different having a registered midwife in the room or on the same floor overlooking everything you do as a clerk, and then having nobody (Claire, Group B).

Another challenge that participants identified for new registrants who did not change midwifery practices, was differentiating themselves in their new role as a midwife. One participant speculated:

> I imagine it would be challenging coming into a new registrant position where you were a student because trying to assume the role of not being a student, and trying to let those relationships go where you had only student-mentor relationships, would be challenging. I did feel a little bit of that, even just being with the practice where I was a student (Karen, Group A).

Some midwifery practices dealt with the potential challenge of hiring on a previous student by organizing the new registrant's mentorship and supervision to be

conducted with midwives other than those who were the preceptors during the new registrant's final year as a student. One midwifery mentor explained that, at her practice:

> If they were a senior student…we will avoid assigning that preceptor as their mentor. This seems to help with the transition from being a student to not being a student because the relationship you had with your preceptor has this way of…persisting in terms of deferring to them and maybe still feeling like a student. So that's another thing that we try to avoid (Madeline, Group C).

Taking on the professional identity of a midwife is a component of Cultural Bridging. Participants described how assuming one's self-identity as a new registrant may be either helped or hindered by previous experience as a student at the midwifery practice. Some practices recognized the challenge that new registrants might encounter with respect to disconnecting themselves from their previous identity as a student, and offered strategies to facilitate transition during this element of Cultural Bridging.

Another element related to new registrants' integration into their midwifery practice, and something that participants were acutely aware of, were issues related to power dynamics and hierarchy within midwifery practices. Participants described a "sense of vulnerability" (Adrienne, Group B) and used phrases like "lower on the totem pole" and "little fish" (Laura, Group A) to describe their perceived position within the midwifery practice. Participants noted that there were times when new registrants felt that they must prove themselves to be hard workers and team players. For example, one participant described a situation she observed:

> I'm noticing that the new registrant is often being asked to stay on call for particular clients on her weekends off, to go to extra births, to do

> extra postpartum visits, to do extra community outreach, and I don't feel like it's fair. It's really unfair for her. And it's all being done courteously and kindly and under the guise or intention of giving her more clinical experience but I don't feel like it's fostering a healthy work-life balance viewpoint. So that's where I feel like I'm helping her the most is just letting her know that it's ok to say no, that she actually should say no so that people know that she has boundaries and also so that the people who follow after her are not expected to do all the same things (Olivia, Group B).

This quotation illustrates how power dynamics within the midwifery practice may lead to new registrants feeling pressure to take on more work, stay on call during scheduled off call time, and work longer hours before calling for relief than other individuals at the midwifery practice. Interpreting the dynamics, relationships, and expectations that arose from the culture within a midwifery practice was a challenging component of Cultural Bridging for participants, especially when they did not feel they had the authority to advocate for themselves.

Practices' communication with new registrants, specifically communication surrounding the possibility of continuing work at the practice beyond the new registrant year also challenged participants' integration into a practice. Many participants did not receive clear communication from their midwifery practices as to whether or not their contract would be extended beyond the new registrant year. Some participants had a strong sense that their contract would not be extended beyond the new registrant year, based on their own knowledge of midwifery in their respective communities. Karen explained:

> I'm probably not going to have a job next year. In [this city], at least, there are no jobs available for the most part. In the city there are [x number of] practices, maybe there are going to be six jobs available in the city as of next year, for general registrants, and that'll be because of mat leaves or midwives that quit, or maybe one or two hospitals that are

> adding privileges, but there's a really big problem with hospitals not increasing privileges and midwives basically not having jobs. So, while it was really fantastic to get a job in my community, I have a very realistic perspective that likely there won't be any work for me (Karen, Group A).

Other participants, such as Sophia, were fairly certain that their contract would continue beyond the new registrant year, despite the practice not explicitly communicating this information:

> There hasn't been any indication that it's a one-year thing. It sounds like it's definitely at least as long as I'd like right now… when I came on… two midwives left, one on mat leave and one just left to another clinic, so I squeezed into either of those positions, but it wasn't said: 'You're only here for a year' so, at this time it seems as though I have a job (Sophia, Group A).

Finally, some participants, such as Adrienne, were left questioning their contract status as the end of their new registrant year approached. Adrienne described:

> Halfway through my new registrant year, I felt like I really needed to know my future, and I did pester them a little bit, and they extended my contract until the end of this fiscal year. And [they] did not extend the other new registrant's (Adrienne, Group B).

A few participants did receive clear communication from their midwifery practice about whether or not their contract could potentially extend beyond the new registrants year. One participant explained:

> I knew coming into this that I may not have a job after a year and that was something I was prepared for. But at the same time I'd like to stay…our life is here, but it's becoming not really an option...[there are] so many midwives here (Bethany, Group A).

This job insecurity was a source of stress for participants, and also presented challenges with respect to how new registrants interacted with midwifery colleagues. During the Cultural Bridging phase, participants strove to integrate into the midwifery

practice culture. This integration was challenged when the culture of the midwifery practice did not include open communication with new registrants.

Further to the lack of communication related to new registrants' ongoing contracts, new registrants were cognizant of power dynamics within midwifery practices and often felt that they had little power to express concerns or bring forward issues, for fear that it would impact their job security. Adrienne described:

> There are two midwives in particular that wield all the power in the practice…And those are the two that were assigned to also supervise the new registrants, myself and the other one. So it also feels difficult that if I have questions or if I have concerns, especially if they're organizational concerns like, I don't like how this was said in a meeting or I feel excluded or confused, I feel like I actually can't voice those concerns without it affecting my future at the practice (Adrienne, Group B)

Adrienne (Group B) went on to explain: "I really need job stability, and if I rock the boat I'm not going to get the job stability". These quotations demonstrated that, despite having an assigned mentor, the midwifery practice culture was not conducive for Adrienne to access these supports when she felt she needed them. The power dynamics of a midwifery practice influenced when and how new registrants sought help and guidance from colleagues. One participant described how she was hesitant to ask questions of colleagues because of the fear of being judged by those who, in the future, would be making decisions about whether or not she would remain in the midwifery practice:

> She's also a practice partner, so I didn't want to ask any questions that would look stupid. You don't want her to think, 'Well, you should know that, I can't believe you're asking that.' So the questions were selected pretty carefully (Charlotte, Group B).

Even when participants were not worried about power dynamics, they still experienced some fear of judgement in requesting help and guidance from their colleagues. One participant explained:

> There [are] a couple midwives that I often go to. And there [were] a couple midwives that I went to a lot in the beginning, and then I've tried to not go to them as much cause I was worried that they were going to think that I didn't have my stuff together. I don't think I was asking unreasonable questions, but at a certain point you don't want to bombard the same person with all your questions (Bethany, Group A).

Participants recognized the power dynamics that were at play within the midwifery practice. When participants viewed themselves as having little power within the practices as a whole, they expressed difficulty seeking help and advocating for themselves. This is a component of the Cultural Bridging phase because when midwifery practices exhibited distinct hierarchies, new registrants often viewed themselves as having little power and thus it was difficult for them to fully integrate into the midwifery practice culture. In midwifery practices that had a structured mentorship system in place, participants more frequently described being able to ask appropriate questions and seek help from more senior practice members without worrying that their questions or concerns would be held against them in the future.

An additional component of Cultural Bridging that participants identified was learning and adapting to the hospital culture. New registrants must communicate with the nursing, obstetric, anesthesia, and other hospital colleagues in their professional capacity and no longer have a preceptor as an intermediary for these interprofessional conversations. Participants were acutely aware of how supportive,

or unsupportive, hospital culture was towards midwives. One participant explained the personal importance of developing interprofessional relationships:

> Getting to know the ward clerks, and the nursing staff, and whoever else is there… just helps all that much more because, at least when you come in, even if they don't know your name, they kind of know what you do, and if you reach out, at least you know that they'll hopefully help in some way (Sophia, Group A).

Another participant explained the difficulty she had unraveling the complexities of the hospital culture within her community:

> There's definitely a culture at the hospital of knowing who you're working with and trying to make different care decisions depending on who [is on call] to try to support your client having a natural birth. So that's also been challenging, to try to figure out how much I buy into that…and if it's necessary, how do I figure it out. How do I try to understand, in this short amount of time, all of the nuances of the people I'm working with? (Karen, Group A)

As with learning and adapting to the midwifery practice culture, participants benefitted from clear mentorship with respect to deciphering the cultural expectations and interprofessional dynamics in the hospital setting. One participant described how she was particularly concerned with how she came across to her interprofessional colleagues:

> [As a student] I had an experience where a consultant approached one of my preceptors and said that she thought that I came across as arrogant or pompous or something like that. I'm kind of shy and not particularly confident when I'm consulting, so it was kind of strange to me that I could be perceived that way but knowing that that's possible and maybe how I overcompensate for my weaknesses can come across as being overcompensating. So [I'm] just being really, really extra careful with how I present myself. Not assuming that the way I present myself is the way that other people perceive me (Laura, Group A).

These quotations illustrated the experiences related to hospital culture that new registrants faced during the Cultural Bridging phase. As participants began working

at the hospital in a professional capacity, rather than in their previous role as learners, they began to build relationships with interprofessional colleagues and understand both the importance and the complexities of interprofessional relationships.

The final aspect of Cultural Bridging was how new registrants situated themselves within the wider midwifery profession; their feelings of belonging within the midwifery community, and their own identity as midwives. One new registrant described feeling a lack of identity as a midwife and being disconnected from the midwifery profession as a whole:

> I certainly don't feel ownership over the midwifery profession. I went to the AOM regional conference…and sat there with my mouth shut because I felt like, here are all these midwives who have been practicing who really own midwifery. And I'm just this new person, even though I'm a midwife. I'm a midwife who's practicing, who has clients, who has the same issues that other people have, but I still don't feel as a new registrant that I have the ability to speak up or participate. And that goes for everything, like, birth center councils, and quality assurance councils and all that stuff, I don't feel like I'm really entitled to be involved quite yet (Karen, Group A).

Another participant explained that as a new registrant she did not feel a sense of community within the midwifery profession:

> I feel like [as] women working in a hard profession together that there was very little sense of teamwork, very little sense of sisterhood, very little sense of supporting each other. And being the new, green midwife on the team I just didn't feel like I was being nurtured. And I'm not expecting to be coddled, I just feel like it would be nice…to nurture the people who are coming into it and help them to have tools for success (Adrienne, Group B).

The final aspect of Cultural Bridging involved how new registrants situated themselves within the wider midwifery profession. In taking on their new professional identity as midwives, it was common for participants to describe a lack of

professional identity when they first entered the profession. Additionally, some participants experienced an overall lack of feeling included in the profession as a whole.

Cultural Bridging represented a complex phase in the transition to clinical practice where new registrants learned and adapted to the cultural norms and expectations of their midwifery practice, the hospital, and the wider community. Participants identified complicated issues related to support networks, power, identity, and situating themselves within their midwifery practice, the hospital environment, and in the broader midwifery community.

4.3.5 *Bridging Summary*

The Bridging phase was, perhaps, the most complex phase in the Building, Bridging, Being theory. Clinically, individuals were no longer supervised by a preceptor and although some practices had a set number of supervised clinical procedures that new registrants were required to complete, overall individuals dealt with clinical situations independently. Participants described this phase as a "roller coaster", experiencing emotional highs and lows, including feelings of freedom and independence, and extreme stress and anxiety regarding the weight of clinical responsibility. Additionally, interpersonal conflict was emotionally challenging for some participants. Along with the Clinical and Emotional components of the Bridging phase, participants identified the Practical elements of the Bridging as particularly challenging. Working through the logistics of the midwifery clinic and the hospital was difficult for participants, as was managing time, prioritizing clinical tasks and

responsibilities, adapting to call models, and understanding the financial and business aspects of clinical practice. Finally, the Cultural elements of the Bridging phases included developing support networks of colleagues, peers, and mentors, and integrating in to the midwifery and hospital culture, and finding ones' identity in the broader midwifery profession.

4.4 Being: Finding Your Stride

In the final phase, Being (Figure 5), new registrants were comfortable and confident with their professional identity as registered midwives and exhibited maturity in their interaction with the Clinical, Emotional, Practical, and Cultural elements of midwifery practice. In this phase new registrants had shed their student skin and truly saw themselves as autonomous health care professionals. During this phase, participants gained confidence in their clinical skills and in the environments where they practiced, recognized the importance of strong professional and personal support systems, and acknowledged the inherent unpredictability of midwifery practice. Sophia summarized the Being phase well when she said: "I guess that's what the new grad year is: finding your stride and gaining confidence" (Sophia, Group A).

BEING
CLINICAL
• Confidence in clinical situations • Learn from and adapt to unfamiliar clinical situations
EMOTIONAL
• Freedom to develop personal practice style • Self-identity as a midwife • Professional satisfaction
PRACTICAL
• Confidence in logistics
CULTURAL
• Accepted as an equal team member

Figure 5 – The Being Phase

4.4.1 *Clinical Being*

In contrast to the Clinical Bridging phase where participants questioned the decisions they made, in the Clinical Being phase, participants had confidence in their clinical decisions. One participant explained:

> I just want to feel really confident in my practicing, and I basically want everything to feel second nature as much as it can, I know you can never predict anything or everything (Sophia, Group A).

One participant described her experience of working at a small, rural practice where she was primarily doing independent clinical visits. She described how these circumstances built self-confidence in her clinical skills:

> I'm doing clinic completely on my own because there's only three [of us]. We have our own clinic days, so there's not even another midwife in the clinic when I'm conducting visits, so if I'm unsure about a palpation I can't just get another midwife to come in and double check…So that has been a big shift. I'm getting used to it now, I feel like I'm kind of settling into that, but initially that was quite challenging and nerve wracking (Wendy, Group A).

During the Clinical Being phase, aspects of clinical practice that were once a source of anxiety, became familiar and even second nature, and participants explained that clinical decision making did not require as much mental and emotional energy. As one participant explained:

> I would wonder if I was missing something…Now that I'm practicing on my own it's nice to have the freedom to just decide, if I'm not comfortable with something, to send them for a test (Karen, Group A).

In recounting an experience dealing with a new clinical situation, another participant said: "I thought on my feet and…I did the best that I could do in that situation and all of a sudden I [realized], 'Ok, you're just doing it' " (Sophia, Group A). The experiences of Wendy, Karen, and Sophia illustrated the clinical confidence that was characteristic of the Clinical Being phase.

During the Clinical Being phase, participants also realized that their clinical learning would continue beyond the new registrant year. One participant explained how regularly reviewing births as a midwifery practice group was valuable for her clinical confidence:

> It gave us all an opportunity to say, 'I really wish that I hadn't done this…' or 'I feel like maybe I could have done this differently'…and it was so, so helpful. [It] gave me an opportunity to see the humanity in the more senior midwives around me who were also maybe having regrets about doing x,y,z. It also gave me an opportunity to learn vicariously through their experience…[and] definitely helped me to gain confidence (Olivia, Group B).

In contrast to the Clinical Bridging phase where participants were dealing with clinical situations independently for the first time, in the Clinical Being phase participants had more experience, and thus greater confidence with most clinical situations and were able to effectively make clinical decisions to manage new or unfamiliar scenarios. Additionally, it was during the Clinical Being phase that participants recognized that clinical learning continued through one's midwifery career.

4.4.2 *Emotional Being*

During the previous Emotional Bridging phase, new registrants reacted to the emotions that accompanied the increased responsibilities of clinical practice; however, in the Emotional Being phase, they managed, responded to, and reflected on these emotions. While the Emotional Bridging phase was described as "a bit of a roller coaster" (Bethany, Group A), the Emotional Being phase was characterized by an overall improvement in confidence. One participant felt that as an autonomous midwife she was finally able to be herself and have "a personality that [she] actually

valued, rather than needing to constantly be in performance mode" (Adrienne, Group B). For participants including Adrienne, the freedom of autonomous practice afforded the opportunity to truly be themselves and to develop their own personality as midwives.

> I'm pleased at how much easier it is to be a new registrant…I no longer feel terrified, like, even when I'm managing [an emergency] or something, I'm like, 'Oh, this is a breeze because there's no one who's judging me right now'…[I have] a bit more skill that has come with an additional year of practice, but it's just nice to be free (Adrienne, Group B).

During this phase, participants described embracing the independence and autonomy of clinical practice. Instead of the absence of a preceptor creating stress as it did in the Emotional Bridging phase, participants experience the freedom to cultivate their own clinical practice styles. One participant drew particular attention to the feeling of empowerment she had when she was able to truly practice independently:

> Being at a birth on my own where it was just me and the client in the room and being able to just be juggling what was going on in the moment with her and with me, and not be considering all of the other politics and the energy levels of the people I'm working with and the style of the different people I'm working with, just being able to say, 'What do I want to do? What feels right to me?' And just do that, has been really empowering (Karen, Group A).

The quotations from Adrienne and Karen demonstrated how, during the Emotional Being phase, the positive emotions associated with new registrants' clinical practice were no longer clouded by negative emotions such as stress, fear, and anxiety. During the Emotional Being phase, new registrants were able to truly experience the satisfaction that came with practicing their chosen career.

Perhaps the most profound realization that marked the end of the Bridging and the start of the Being phases was that the stress and uncertainty of clinical practice did not end with the new registrant year. One participant articulated:

> The more I practice the more I recognize there are so many other things beyond my control and the fact that I feel like I'm supposed to control them that's also a hard thing to keep in mind. Some things I just do not control. I'm responsible for a lot, but I also can't accept responsibility for things that aren't mine (Katie, Group B).

Another participant expressed how she felt when reflecting on challenging clinical situations:

> I think in the moment it seems really challenging and really bumpy and then I look back and [think]: 'But I made it through so it can't be that bad.' And I'm still smiling and I still enjoy what I do, so it's all good." (Sophia, Group A)

In the Being phase, participants realized that midwives can never be prepared for every possible clinical situation. Although dealing with difficult situations was certainly stressful in the moment, participants in the Emotional Being phases did not find dealing with difficult situations as overwhelming as they did during the Bridging phase, and instead were able to seek support when necessary.

Another element of the Emotional Being phase was participants' self-identity as midwives. While, technically speaking, as soon as new graduates are registered with the College of Midwives of Ontario (CMO) they are registered midwives, for many new registrants it was not until part way though their first year of clinical practice that they truly saw themselves as midwives. One participant reflected that partway through her new registrant year "something clicked" and she truly saw herself as a midwife:

> I felt like there was a point about three quarters of the way through my new registrant year where I pretty much knew how I was going to manage most common scenarios. I had confidence with my clients and I knew them really well by the time they were due because I had been there a number of months before they were due…Something clicked and I got a lot more confident and really felt like a much more autonomous midwife…I would say it wasn't until then that I was like 'Yes, I really am a midwife' (Olivia, Group B).

Similar to Olivia, many participants' self-identity as a midwife and job satisfaction were closely linked to the relationships they had with their clients; participants felt deeply rewarded by the relationships that they built:

> I really like the fact that the clients are my clients. They kind of were my clients anyway as a student, but now they're really my clients. And the best part is having repeat clients. I've already had two repeat clients as a new registrant (Bethany, Group A).

Closely linked to participants' self-identity as midwives, were their feelings of satisfaction with their chosen career. When participants were in the Emotional Being phase, they appreciated the unique aspects of the midwifery profession and the role that they played in the lives of their clients; they began to truly take on their identity as a midwife and experience satisfaction with their chosen profession. One participant expressed:

> Sometimes I'm like, 'Why did we do this job? Why do we do it? Seriously.' But, then you're like, 'No, this is why we do it…' And talking to friends who work a nine-to-five job or do something where they don't really know what they're doing yet, I definitely think that it solidifies why I'm doing what I'm doing and I wouldn't trade it for anything else (Sophia, Group A).

Participants in the Emotional Being phase expressed feelings of freedom and confidence in their autonomous clinical practice. During this phase, individuals developed their own practice style, which enabled them to take on their self-identity as a midwife and to feel satisfied with their professional role.

4.4.3 *Practical Being*

Throughout the Practical Bridging phase participants were challenged to independently balance a multitude of tasks and responsibilities associated with clinical work. In the Practical Being phase, participants demonstrated the ability to prioritize the tasks of the midwifery clinic, hospital, and community, and the logistics of clinical practice were no longer overwhelming. One participant illustrated the process of becoming more comfortable with the numerous tasks required when admitting a client to hospital:

> The first few times going to hospital for births I remember thinking, 'Oh my god. What do I do when I get there?'… whereas [now] it kind of just seems like, 'Alright, when I get there, I'll get there, and this is what we'll do.' And it just seems like second nature now; already it's getting more to be second nature…At first…I had to go through this list in my head slowly to get it all ready. And then you realize it doesn't matter if the room's set up perfectly or you don't have your blood work done right away when you get there; you do it an hour after you get there. It's fine, I'll just cover all bases eventually (Sophia, Group A).

During the Practical Being phase, participants took the challenges that they faced during the Practical Building phase and implemented strategies that helped them better manage these responsibilities. During this phase participants enacted strategies to help them manage their time and prioritize responsibilities related to conducting clinic, managing administrative tasks, and adhering to hospital policies and protocols.

4.4.4 *Cultural Being*

In the previous Cultural Bridging phase, participants struggled with situating themselves within the midwifery practice and the hospital community and did not feel that they possessed the authority to contribute opinions and ideas, offer criticism, or

make decisions. The predominant characteristic of the Cultural Being phase was that participants saw themselves as part of the team, both in their midwifery practice and in the hospital setting. New registrants felt included in the day-to-day activities of the midwifery practice and had confidence to offer input and suggestions that contributed to the operation of the practice group:

> They're a very supportive practice in many ways. They really include me in how the practice is run and kind of what the future of the practice will look like. And I feel like they're not really treating me like this new registrant who's kind of an underling or anything like that. They're really…embracing me as an equal team member, which is really positive (Wendy, Group A).

Another participant described similar sentiments when she elaborated on how her new registrant year "[had] been fantastic":

> Things have really lined up in a really amazing way for me. I'm feeling very grateful… it's been really wonderful to be at a practice where it feels like I've been integrated really well. They have helped me to be part of the team, and obviously that's a huge difference from being a student at most practices, actually being taken seriously…having the midwives who you're working with trust [you]…and respect the decision that you're making…and just [support] you (Karen, Group A).

One participant from Group C explained how she hoped that her midwifery practice fostered a culture where new registrants felt comfortable speaking up and providing input into the decisions of the midwifery practice:

> In addition to our willingness to be present, is a willingness to listen to other ideas. So, we've had new registrants bring up ideas [like], 'Why are we approaching it this way?' 'Why wouldn't we do it this way?' I think there needs to be…a culture of: That's okay to question even the most senior midwives about their clinical practice…it's not that we always turn everything upside down because of a new registrants suggestion, but it's okay to say: 'This might be a way to approach it.' And I'm hoping that they feel welcome to share those ideas (Madeline, Group C).

Within the hospital setting, Cultural Being involved participants developing interprofessional relationships and feeling included in the obstetrical team. For one participant, having a chance to communicate with an obstetrician following a difficult clinical situation contributed to her feeling integrated into the hospital culture:

> The OB was amazing. She sent me an email afterwards and told me she thought everything I did was appropriate. So that was good… especially as a new midwife, it's good to get feedback (Bethany, Group A).

In a more casual context, Sophia described a situation where she appreciated the relationships she had with the nurses she worked with:

> Having the nurses on board has really made a difference in terms of [support. Like] when I'm alone at 4am and I haven't really talked to anyone else all night except [the client] (Sophia, Group A).

The examples of Bethany and Sophia illustrated how new registrants were able to develop interprofessional relationships in both clinical and social situations. These interprofessional relationships and integration into the wider hospital context were an important feature of Cultural Being phase.

Whereas Cultural Bridging was characterized by many discrete elements of the midwifery practice and hospital culture, in the Cultural Being phase, all of the previous issues were distilled into one central issue: new registrants being integrated into the midwifery practice and hospital cultures, and being seen as equal team members.

4.4.5 *Being Summary*

During the Being phase, participants described being more comfortable with the Clinical, Emotional, Practical, and Cultural elements of midwifery practice. They

were able to manage clinical sitautions with confidence, and could better learn and adapt to unfamiliar circumstances. Emotionally, participants descibed feelings of professional satisfaction and their self-identity as midwives. Instead of experiencing stress related to the Practical aspets of clinical work, participants described confidence during thie Being phase. Finally, within the culture of the midwifery practice, hospital, and wider community, partipcants felt welcomed and accepted as equal team members during the Being phase.

4.5 Bettering

Interview participants were asked to reflect on their own personal experience as new registrants and were given the opportunity to offer recommendations to facilitate the transition to clinical practice for other new registrants. While this section of the findings is not part of the overall Building, Bridging, Being theory, the suggestions that participants identified comprise the Bettering theme and are also aligned with the four sub-themes of Clinical, Emotional, Practical, and Cultural (Figure 6 - Bettering).

BETTERING
CLINICAL
• Emergency skills practice • Review learning needs
EMOTIONAL
• Peer support networks
PRACTICAL
• Comprehensive orientation • Professional development
CULTURAL
• Formalized mentorship • Integrate new registrants into the midwifery practice

Figure 6 – Bettering

4.5.1 *Clinical Bettering*

Overall, participants felt competent with respect to their clinical skills; however, emergency skills were a persistent source of stress for new registrants. Participants recognized midwifery clients – typically a healthy, low-risk population – offered

relatively few opportunities to employ emergency skills; consequently participants suggested that practicing these skills through simulation and drills was a realistic way to maintain proficiency in the techniques and procedures for emergencies such as neonatal resuscitation, postpartum haemorrhage, shoulder dystocia, and cord prolapse. One participant suggested having regular sessions to review and practice emergency skills was one way to address this need. This participant said:

> When I was a senior student we'd do review with the incoming students, and we'd have the clinical skill days, but I think it would be nice to have something as well as, like an NR, a newer midwife just going through those things beyond the yearly training that we do…And I know we're going to be doing some [neonatal resuscitation] and intubation review… it's good to be fresh on those skills (Bethany, Group A).

Participants also suggested that reviewing learning needs with their midwife colleagues would be beneficial. Just as a midwifery student sits down with a clinical preceptor at the beginning of a clinical placement to review specific skills the student needs to work on, new registrants could benefit from discussing learning needs with a mentor and checking-in about the progress of meeting those needs over the course of the new registrant year. One participant explained this idea:

> I think much like when we start out clinical placements as a student and you identify your areas of need, or your knowledge gaps, I think that's a fair thing to sit down, regardless of where you are, even if you're at the same practice, and identify, is there anything that you feel less competent and even if it's IV starts, or blood draws, or if it is oxytocin because you've never run the pump, obviously those are big gaps, but I don't think it's a bad idea if every midwife, no matter where you're starting, if you've been there or not, went through a general, 'Okay, where are your gaps and what can we do to fill them?' and then have a check-in, whether it's two months later, or three months later, however much it is, at least a couple check-ins scheduled to see how it's going from there, I think that would be a good start at least (Sophia, Group A).

In general, participants felt adequately prepared for clinical practice with respect to their clinical skills, although the area of emergency skills were a persistent area of concern. Participants identified that regular emergency skills review may help address this clinical need. Additionally, participants suggested that it might be beneficial to discuss ongoing learning needs with their colleagues when they commence clinical practice, in order to identify areas where they may need additional support.

4.5.2 *Emotional Bettering*

As participants moved through the Building, Bridging, and Being phases, support from family, friends, and colleagues was essential. As described in the Emotional Bridging phase, new registrants accessed support from various new and existing support networks. While some participants stayed in touch with peers through various informal avenues, particularly online social media platforms, participants suggested that a more organized means of staying connected with fellow new registrants across the province would be beneficial to their emotional well being. One participant explained:

> I think it would be lovely to have an online forum for new registrants to meet and support each other and ask questions. Not necessarily clinical questions, but organizational questions and time management questions. Questions about the dreaded taxes, how to keep track of your mileage, things like that (Adrienne, Group B).

Similarly, another participant described how, as a new registrant, she found value in some informal, online forums and wondered if a more formal online platform would be beneficial:

> I could have used…a more universally accessible platform for discussions between new registrants. Because I know the AOM has, supposedly had some message board that new registrants come together to discuss but no one ever used it so it was mostly person to person interactions; what's developing now is that each graduating year in each school has got their own little Facebook group that they use to support each other…So now I'm finding the Facebook page for Canadian Registered Midwives just as enlightening. Just as the page was for my graduating year last year, I feel like evolving towards those social media avenues…would be helpful (Olivia, Group B).

Although, as described in the Emotional Bridging phase, participants were able to develop their own support networks through their first year of clinical practice, this process was sometimes difficult. Participants asserted that they would have appreciated a more organized forum to connect with their peers; a need that validates the Emotional dimension of transition to clinical practice.

4.5.3 *Practical Bettering*

One of the most significant Practical challenges for participants involved navigating the midwifery logistics related to call models, caseload, clinic scheduling, off call time, and relief. In reflecting on recommendations to improve the transition to clinical practice, participants indicated that it would be helpful for midwifery practices to provide comprehensive orientation to midwifery practice logistics, including how caseload is assigned, how call models are organized, and how off call time, holidays, and relief are determined. One participant described how she appreciated having clear, consistent guidelines and communication within her midwifery practice:

> I think having a lot of transparency has been really helpful. I didn't feel like I had to ask more than once to get clear answers from the practice about what their expectations of me were, how things work, how I'm going to get paid, what my caseload will look like. All of that was really structured, and seemed really reasonable, and was slightly flexible…I felt like their responses to my questions were really reasonable and if I

> had ideas about changing things to make them work better for me there was openness to that, but coming in, it was laid out for me really clearly: 'This is the call model we're expecting you to work in, this is the number of cases we're guaranteeing that you'll have, this is our pay structure' (Karen, Group A).

Along with orientation to the midwifery practice logistics, participants identified the need for a thorough orientation to hospital protocols and procedures. One participant explained how she valued the orientation that her practice provided to all new registrants:

> Someone who's coming from a different community is really starting from scratch learning the hospital…Whereas someone who's been a clerk in our practice can really hit the ground running with a lot of that information. We still will do an orientation for a couple reasons, one is to make sure that there's not some details that say, the preceptor is normally taking care of…or has to do with something that was not a student responsibility, so we just still run through the whole thing (Madeline, Group C).

Another idea that fit with the concept of Practical Bettering was to offer professional development sessions designed specifically for new registrants. For many new registrants, several months elapsed between graduation and the opportunity to begin clinical practice. This time frame presented an ideal window to offer professional development sessions geared specifically towards the needs of new registrants. One participant explained how offering professional development sessions, either in-person or through a web-based forum, could address common issues that arise throughout the first year of practice while at the same time allowing new registrants to connect with peers and. She said:

> Maybe some web information sessions that were at designated times of year where as a new registrant it's normal and expected to take two hours off to go to the info session, because just in my practice to take two hours to do a webinar or something like that, it's like you're pulling teeth to get permission to do it. They just don't organizationally support

> that very easily. So if it was a normal expectation that you would have to do these additional learning modules I think that that would give me permission to learn and explore the things I need to and now it seeming like I'm asking for a favor (Adrienne, Group B).

As emphasized in this quotation, providing designated off call time to participate in this type of professional development was also suggested as a way of supporting new registrants.

One prevalent challenge during the Practical Bridging phase was understanding logistics related to midwifery and hospital protocols and policies; as such, participants suggested that offering comprehensive orientation to both midwifery practice and hospital logistics was a key component to developing practical competence and confidence. Professional development and education geared specifically towards new registrants was suggested as a means to help meet some of the practical needs of new registrants during the months following registration.

4.5.4 *Cultural Bettering*

As was discussed in the Cultural Bridging phase, a positive mentoring relationship was beneficial for new registrants progressing through this phase; it follows that participants' primary suggestion relating to Cultural Bettering was to have formal guidelines and expectations between new registrants and mentors. The mentorship structures that participants experienced through the Building and Bridging phases varied significantly, and interestingly, assignment of a mentor to each new registrant was not sufficient on its own to support for the transition to clinical practice. Despite having an assigned mentor, many participants felt that their

mentorship needs and expectations were not met. One participant explained how she was surprised when she realized that there were no formal guidelines to support mentorship:

> Having been in placements where you're constantly getting feedback and going through rigorous supervision, I didn't know if it was something set up like that where I was having all these weekly check-ins or bi-weekly, or monthly or anything else… So I guess I just thought our college must have had something and there isn't. There really isn't (Sophia, Group A).

To this end, participants suggested that formalizing the mentorship structure would improve access to mentorship and would help meet the mentorship expectations that new registrants had upon commencing clinical practice. One participant articulated:

> Having a rough guideline of what expectations are between a mentor and a new registrant would probably be a good idea. Like, a general contract that you read through and agree so you know who you're calling at what time, and if you're supposed to call that person or not and things like that. And…each clinic could change it to their own standards of how they do it, but at least a rough guideline would be, I think helpful, for sure. In a time of so much grey anyway as a new grad …it would be nice to have one cut and dry thing (Sophia, Group A).

Along with the suggestion to formalize the roles, responsibilities, and expectations of the new registrant-mentor relationship, participants suggested that training and support be available to mentors in order to strengthen mentorship effectiveness and competence. One participant from Group C, explained:

> There's not a whole lot of…support for mentors themselves. When you're a preceptor, there's all these preceptor workshops and opportunities to exchange ideas, I don't know that there's anything like that for mentors; if there is I've never heard of it. I think that would be helpful sometimes…I don't know what it would look like or what it would be, but if there was maybe a more structured, 'This is what's expected of a mentor'… You do set the tone when you take on someone that's brand new; you can have a big influence on how they end up working and who they are (Jill, Group C).

A significant challenge for participants during the Cultural Bridging phase were feelings of isolation and a lack of support from midwifery colleagues. One participant suggested that it would be helpful for midwifery practices and midwives who work closely with new registrants to examine how they could better introduce and integrate new registrants into the profession at the midwifery practice level:

> A question I [have is]: How much discussion is being had on the level of midwives who are already practicing, about what it means to welcome new registrants? and What [does it look like] to transfer that relationship from a student to [colleague]?…I think it would probably be really useful for those conversations to be had with practices that are hiring new registrants;…[to ask] 'How can we be better at welcoming new registrants, and training new registrants?'…Because people probably don't realize that they're really not great at it (Karen, Group A).

Considering this issue from the perspective of an experienced midwife, a participant from Group C highlighed the importance of integrating new registrants into the day-to-day discussions and decisions of the midwifery practice and "making it really explicit that their voice is welcome" (Madeline, Group C).

The Cultural Bettering theme includes suggestions from participants for ways new registrants can be better integrated into the midwifery profession as a whole. The primary approach suggested was to formalize both the expectations and the responsibilities within the mentor-new registrant relationship. Additionally, encouraging midwifery practices to include new registrants as equal team members, in order to foster feelings of professional autonomy and a sense of professional identity. These suggestions validated the cultural dimensions of new registrant's transition by highlighting the themes of support through mentorship and integration into both the midwifery practice and the broader midwifery profession.

4.5.5 *Bettering Summary*

Participants were asked to offer suggestions to help improve the transition to clinical practice for new registrants. Their suggestions were comprised of the four themes that ran throughout the Building, Bridging, Being theory: Clinical, Emotional, Practical, and Cultural. Clinically, participants suggested that increased practice with emergency skills and reviewing learning needs as a new registrant would be helpful. Having a more formalized network of peer support was suggested as a way enhance Emotional support for new registrants. With respect to the Practical aspects of clinical practice, participants suggested comprehensive orientation to both midwifery and hospital facilities as well as professional development geared specifically to new registrants. Finally, participants suggested that developing a more formalized approach to mentorship for new registrant with clear expectations of both the mentor and the mentee would be extremely helpful to address the Cultural elements of the transition to practice. Overall, participants reflected on their own experience, either as new registrants or working with new registrants, and suggested tangible ways to improve the transition to clinical practice.

4.6 Summary of Findings

The Building, Bridging, Being theory helps midwifery educators, researchers, practitioners, and learners understand the transition to clinical practice for new registrant midwives in Ontario. Clinical, Emotional, Practical, and Cultural factors were evident through each of these phases. The Building phase represented a time of developing the knowledge and skills needed to take on independent clinical

practice. The Bridging phase was a time of cognitive dissonance that was characterized by many challenges related to adjusting to autonomous clinical practice. Finally, the Being phase represented the consolidation of these dissonant experiences and the development of a professional identity as a confident, autonomous midwife. Progression through the Building and Bridging phases to the Being phase was complex and influenced by many factors. The ideas presented in the Bettering category further support the stages and dimensions of the transition to clinical practice and offer a starting point to enhancing support for new registrants as they make the transition to clinical practice.

5. Discussion

5.1 Discussion Overview

This qualitative, grounded theory study was conducted with the purpose of answering the research question: *How do new registrant midwives in Ontario navigate the transition from student to clinician during their first year of clinical practice?* Using interview data, the Building, Bridging, Being theory emerged to describe the phases through which participants progress during first year of clinical practice. Each of these three phases was characterized by Clinical, Emotional, Practical, and Cultural elements. Considering the common experiences that new registrants encountered across these three phases, there are four key elements that were influential in facilitating new registrants' transition to clinical practice (Figure 7 - Navigating the Building, Bridging, Being Theory). These four elements were:

a) Preparation for clinical practice through the opportunity to experience clinical management during the Building phase
b) Orientation to midwifery and hospital logistics and expectations during the Bridging phase
c) Mentorship through the Building, Bridging, and Being phases
d) Ongoing education during the Bridging and Being phases

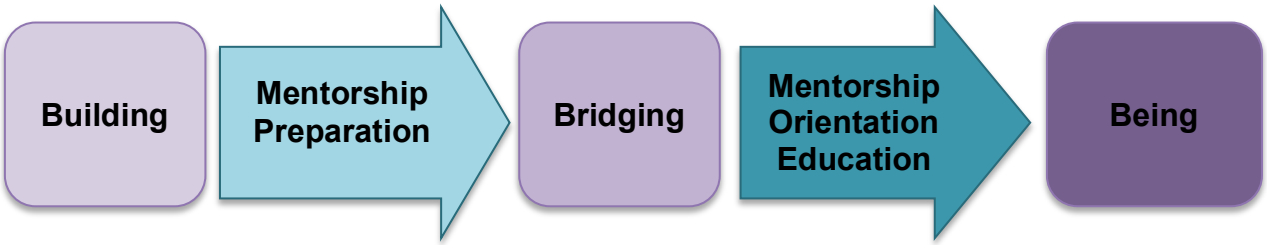

Figure 7 – Preparation, Orientation, Mentorship, and Ongoing Education in the Building, Bridging, Being Theory

5.2 Preparation

Figure 8 - Preparation in the Building, Bridging, Being Theory

The findings of this study identified that, during the Building phase, when senior midwifery students were given the responsibility to make clinical decisions and follow through with care management plans with minimal assistance or modification from their preceptor, they were better prepared to handle the multitude of clinical tasks and responsibilities that came with the independent clinical practice during the Bridging phase (Figure 8 – Preparation in the Building, Bridging, Being Theory).

The Building phase was critical to developing confidence, refining clinical skills, and honing clinical judgment and decision-making. In order to do this, there must be ample opportunity to deal with both normal and complex clinical situations; proposing, initiating, and following through with care management plans during all phases of pregnancy, birth, and postpartum. In learning to manage clinical care, students must be given the space to make decisions independently and to learn from these experiences. These findings align with the research examining the transition to clinical practice in other fields of health care, which concluded that the opportunity to deal independently with clinical situations is a formative step in developing clinical confidence (27,34,36,41,43,47,79). In the final months of the senior student year during the Building phase, midwifery students should have the opportunity to take on responsibility of managing all aspects of antenatal, intrapartum, postpartum, and

newborn care. Participants who had adequate preparation through opportunities to practice clinical management refined their clinical skills and judgment, developed time management, organization, and prioritization strategies, and integrated into the midwifery practice and hospital culture during the Building phase. Upon graduation, although these participants still felt some stress and anxiety related to independent clinical practice and the absence of the safety net of a clinical preceptor, their experience with managing clinical care during the Building phase enabled them to use their knowledge and skills more confidently through the Bridging phase and ultimately enhanced their ability to reach the Being phase of the transition to clinical practice.

In contrast to participants who had adequate clinical management experience during the Building phase, some participants of this study experienced clinical management for the first time when they began working as a new registrant. Instead of being given opportunities to initiate and follow through with care management plans during the Building phase, these participants were supervised very closely and not given adequate space to develop and follow through with care management plans. While participants felt confident in their clinical skills, the weight of clinical responsibility and independence caused greater stress and anxiety in these individuals and the emotional and practical impact of never having truly managed clinical care was noticeable for these participants. Additionally, instead of new registrants implementing organizational and time management strategies that they developed in the Building phase, these individuals needed to develop and refine these skills during the Bridging phase without the inherent support of a clinical

preceptor or peer tutorial group. While developing the skills and confidence in managing clinical care, research shows that it is common for learners to seek reassurance and validation from more experienced colleagues (35,36,41). This need for reassurance and validation was apparent in new registrant midwives; however, it is preferable for midwives to experience clinical management for the first time when they are students, rather than as new registrants, given that students have the emotional and clinical support of a preceptor. Interestingly, while some participants were aware that they were supervised very closely during their time as a senior student, other individuals did not realize just how closely they had been supervised until they commenced clinical practice.

In the final year of clinical education, it was critical for midwifery student to have the opportunity to practice clinical management during normal and emergency situations through all phases of antenatal, intrapartum, postpartum, and newborn care. New registrants who did not have adequate opportunities to practice clinical management during the Building phase relied more heavily on the support of midwifery colleagues during the Bridging phase and also experienced more stress and anxiety related to the weight of clinical responsibility. For these reasons, supporting both senior students and their preceptors in developing students' clinical management skills during the final year of clinical placement is beneficial for new registrants and may help new registrants be better prepared for the increased clinical responsibility of the Bridging phase. An emphasis on the importance of clinical management experience during discussions between clinical preceptors and midwifery learners may help preceptors adjust their teaching style to support senior

students in practicing clinical independence. A focus on clinical management may also help senior students advocate for themselves and take on the necessary level of clinical responsibility so they are better equipped clinically, emotionally, and professionally to be fully independent after graduation. Experience with clinical management during the Building phase has far-reaching implications for the transition to clinical practice through the Bridging phase as new registrants move towards the self-efficacy and clinical confidence of the Being phase.

5.3 Orientation

Figure 9 - Orientation in the Building, Bridging, Being Theory

Upon commencing clinical practice, new registrants must learn to negotiate the practical logistics and the cultural expectations of both the midwifery practice and the hospitals where they are working. New registrants across the province would benefit from a more consistent approach to orientation to both the midwifery practice and the hospital where they will complete their new registrant year (Figure 9 – Orientation in the Building, Bridging, Being Theory). In this study, a common assumption across participant groups was that new registrants who have had previous experiences at a midwifery practice or hospital had an easier time transitioning from the Building phase to the Bridging phase because they were

familiar with the logistics of the midwifery practice and hospital. This assumption did not always hold true, however, as participants in the Bridging phase identified that one of the most stressful elements of beginning clinical practice was managing the logistics related to working within a midwifery practice and hospital, regardless of their previous clinical experience. For this reason, a recommendation arising from this study's findings was that all new registrants should receive comprehensive orientation to both midwifery practice and hospital logistics, regardless of their previous clinical experience.

Most study participants expected that they would receive some sort of formal, organized orientation to their clinic and hospital workplace as a new registrant; however, the orientation that participants received was inconsistent across midwifery practices. Individuals who received comprehensive orientation to the practical elements of the midwifery practice and hospital were better prepared to embark on independent practice and felt more supported and welcomed into their role as professional midwives. Conversely, individuals who did not receive organized orientation during the Bridging phase struggled to understand the practical and cultural elements of clinical practice.

Literature surrounding the transition to clinical practice emphasizes the difficulty that new health care professionals have becoming familiar with the overall health care system or institution (27–30,32,35,38,41,42,46,47). Additionally, studies examining the transition to clinical practice for nurses and midwives in other jurisdictions have found that new graduates experienced more stress, anxiety, and sometimes even feelings of abandonment, when they do not receive the orientation

and support that they expect (80). This study's participants reflected similar sentiments, as new registrants faced the challenge of balancing a multitude of clinical tasks and responsibilities, and had difficulty in the Bridging phase when they did not receive adequate orientation to the midwifery practice, hospital, or community logistics.

Within a midwifery practice, orientation should include an introduction to the physical space of the clinic, and an explanation of the expectations regarding call schedules and off call time, calling for relief, scheduling clinic appointments, booking ultrasounds and organizing lab investigations, communication and paging, documentation, and the process of completing monthly billings. Orientation at the hospitals should similarly include a tour of the physical space where midwives work, as well as common hospital procedures such as triage assessments, admissions, consultations, ultrasound and lab investigations, postpartum admission, discharge protocols, and documentation. In order to better support new registrants in adapting to the challenge of logistics in the Bridging phase, comprehensive orientation should be provided to all new registrants, regardless of the new registrant's previous experience in the Building phase.

5.4 Mentorship

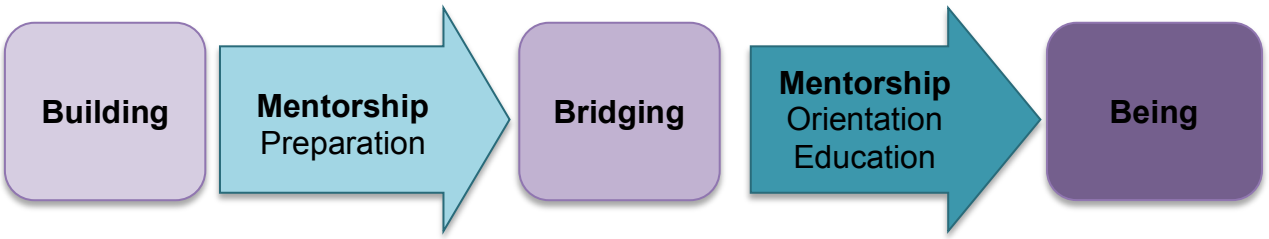

Figure 10 - Mentorship in the Building, Bridging, Being Theory

As new registrants move through the Building, Bridging, and Being phases they develop and draw on a number of supports at various points along the way. The participants of this study clearly articulated that a structured mentorship program offered the most effective and efficient means of orientation to, navigating around, and making sense of challenging experiences during the new registrant year (Figure 10 – Mentorship in the Building, Bridging, Being Theory). During the Building phase, participants experienced mentorship through both their clinical preceptors and other midwifery colleagues. Mentorship during the Building phase enabled midwifery learners to gain exposure to and experience managing a variety of clinical scenarios. Positive mentor relationships during the Building phase facilitated senior students' participation and integration into the midwifery practice and hospital culture and helped foster intraprofessional and interprofessional relationships. Additionally, positive mentor relationships with clinical preceptors and midwifery colleagues enhanced learners' confidence, which translated into confidence as new registrants. Mentorship from clinical preceptors and other colleagues through the Building phase facilitated a smooth transition into the new registrant year.

Subsequent to the Building phase, new registrants in the Bridging phase were better able to work through the Clinical, Emotional, Practical, and Cultural challenges of commencing clinical practice when midwifery practices had structured mentorship programs. Having an assigned mentor who provided orientation, formal and informal feedback, and who was available to answer questions and debrief clinical situations enabled new registrants to progress towards the Being phase. Mentorship during the Bridging phase promoted feelings of confidence, aided in organization and

prioritization of clinical responsibilities, and contributed to feeling accepted as an equal member of the midwifery practice and wider midwifery professional community.

The strong role that mentorship played in the midwifery transition to clinical practice is supported by findings of mentorship in other fields of health care where mentorship is viewed as an essential factor in the processes of transitioning new graduates into clinical practice. Mentorship assists new graduates in developing organization, time management, and prioritization strategies, and also contributes to overall job satisfaction (27–32,39,43,48). As in other fields of health care, midwifery mentors act as a neutral source of information and support for the new registrants, answering questions, providing feedback, debriefing, and offering guidance in a confidential, supportive, non-judgmental way. Although many midwifery practices do organize some form or mentorship to support their new registrants, without midwifery mentorship guidelines, these practices vary widely in the structured support new registrants can access.

The majority of new registrants who participated in this study expected that they would be supported through mentorship when they began clinical practice. Unfortunately, a number of study participants indicated that the level of support and structure of mentoring fell well below their expectations. The primary reason that new registrants' mentorship expectations were not met was because the midwifery practice did not have an organized mentorship program in place. New registrants felt unsupported if their mentorship expectations were different from those of the midwifery practice, or if relationship between the new registrant and the mentor were not a good fit. In other studies examining the experience of newly graduated

clinicians in midwifery and in other fields, graduates recommended the implementation of mentorship programs if a structured program was not already in place (31,34,46). These research findings from other fields of health care were reflected in the Bettering theme of this study, where participants suggested development of structured mentorship programs for Ontario new registrants.

Mentorship during the initial months of clinical practice may also offer long-term benefits in a midwife's career. In 2011, Versaevel conducted a survey examining the reasons that midwives in Ontario remain in the profession (65). The results found that facilitating support systems for newly graduated midwives have a positive impact on individuals beyond the new registrant year and may even contribute to overall improved retention of midwives within the profession (65). Consistent with these findings, Cameron (2011) found that Ontario midwives who left the profession often identified that they did not receive adequate support at the beginning of their career (54). This finding is also echoed within the nursing profession where mentorship in the first year of clinical practice impacts overall retention within the profession (57,60). If mentorship during the first year of clinical practice does, in fact, impact midwives' continuation in the profession, it should be a focus for midwifery practices and, in a broader context, presents a clear approach to enhancing the sustainability of the midwifery profession in Ontario.

One final element that must be considered when discussing mentorship is the training and support for midwifery mentors. While training and support programs exist for clinical preceptors, there is no formal process for selection, training, or assessment of midwifery mentors. Although there is financial compensation

available for midwives who take on the role of mentor, there are no clear expectations of what the relationship between new registrants and mentors involves, nor are there guidelines to clarify the roles and responsibilities of midwifery mentors. Instead, individual midwives or midwifery practices are responsible for developing their own mentorship programs, and do so with varying degrees of success. Mentorship provides critical support to new registrants throughout the Building and Bridging phases of the transition to clinical practice. The findings of this study align with mentorship literature in other fields of health care in the assertion that providing strong, consistent mentorship for new registrants not only supports midwives during their first year of clinical practice but may also contribute to the overall sustainability of the midwifery profession. Formalizing the expectations, responsibilities, and processes related to mentorship, defining clear goals of the new registrant-mentor relationship, and providing training and support for midwifery mentors are the first steps towards developing a more structured, supportive, and effective mentorship program for Ontario new registrants.

5.5 Ongoing Education

Figure 11 – Ongoing Education in the Building, Bridging, Being Theory

One of the most difficult elements of the new registrant year was the conclusion of the formal support systems and the deterioration of the informal support networks that midwifery students relied on throughout their training. Communication with peers, interaction with clinical tutors and preceptors, and opportunities for formal and informal evaluation provided midwifery students with multiple sources of information and feedback during the Building phase. With the start of the new registrant year, most of these regular interactions were eliminated, leaving new registrants to build new networks of support and feedback. In addition to feeling disconnected from midwifery peers, new graduates also felt disconnected from the profession as a whole. The challenge of feeling connected to one's peers and profession upon commencing clinical practice was supported by studies of new graduates in other health care professions who experienced similar feelings of abandonment when faced with independent clinical practice (28,29,34).

The months following graduation present a unique opportunity that may be particularly suited to establishing peer support networks and nurturing new registrants' professional identity. For many new registrants there are several months between the time of graduation and when new registrants obtain hospital privileges and begin on call clinical practice. Offering ongoing education opportunities during the initial months of the Bridging phase could address some of the common experiences and challenges that new registrants encounter, while also allowing new registrants to feel better connected with peers within the profession (Figure 11 – Ongoing Education in the Building, Bridging, Being Theory). A 2011 study that examined the experience of newly qualified midwives in England found that the

transition to clinical practice was more difficult when there were more than 12 weeks between the time of qualification and new graduates' commencement of clinical practice (81); this finding is important to consider in the context of midwifery in Ontario given there is often a delay of several months between new registrants becoming qualified and commencing clinical practice. Some participants of this study noted that this delay in starting clinical practice was challenging, both clinically and financially. Providing education and professional development sessions during this time may help new registrants continue to feel engaged in midwifery both clinically and professionally prior to starting clinical practice.

While some new registrants maintained contact with their peers and interacted with other midwives through online social media forums, many study participants suggested that they would appreciate having a more formal forum to interact with and support one another. A variety of formats would be well suited to providing ongoing support for new registrants through their first year of clinical practice, particularly online discussion forums and in-person or web-based workshops. Study participants suggested that workshops specifically focused on topics relevant to new registrants would help address some of the common challenges throughout the Bridging phase. This recommendation aligns with the findings of Versaevel's 2011 study, which suggested that including practical support for new midwives and creating formal and informal support networks may benefit new graduates in their first and subsequent years of clinical practice (65). Professional development sessions offered over the course of the new registrant year could effectively address clinical and practical issues that are relevant to new registrants, while fostering

professional support networks. Based on the needs identified through this study, some educational topics may include financial planning, emergency skills, working with mentors, and interview skills.

Aside from the content and timing of professional development sessions, one important consideration is accessibility. New registrants are situated across the province, and although offering professional development sessions online helps address geographic barriers, one additional obstacle for all midwives is the ability to participate in workshops while on call. Midwives may struggle with organizing call coverage to participate in professional development activities such as workshops and conferences and new registrants have additional difficulty requesting time off call when they are just learning the expectations of their own midwifery practices. If, as part of the transition to clinical practice, new registrants were expected to participate in professional development sessions and be off call at designated times for these sessions, these clear expectations would alleviate some of the anxiety related to negotiating additional off call time.

Educational sessions and the professional networks fostered through professional development have been found to help new midwives feel better supported and included midwifery as a profession (80,82). One of the challenges during the Bridging phase was new registrants' tenuous sense of identity within the midwifery profession. In addition to enhancing knowledge and skills, professional development sessions for new registrants would provide a forum for new registrants to share clinical experiences, debrief, and create new professional networks. The opportunity to enhance knowledge and skills through professional development may

have the additional benefit of helping new registrants feel integrated into the wider midwifery community and develop their own sense of identity as a midwife.

5.6 Summary of Building, Bridging, Being, Bettering

The emerging theory from this research illustrates the transition to clinical practice throught three phases: Building, Bridging, and Being. In exploring each of these phases, and in considering participants' suggestions within the Bettering category, four factors should be considered to support new registrants in their transition to clinical practice. These four elements are: Preparation, Orientation, Mentorship, and Ongoing Education. Focusing on these four elements when considering ways to support the transition to clinical practice has practical implications for those involved in the education, support, and regulation of midwives. These implications and recommendations will be outlined in the next chapter.

6. Implications

6.1 Implications of Findings

The question of how new registrants navigate the transition from student to clinician is relevant to individuals and organizations who invest time, energy, and resources into the integration of new registrants into the midwifery profession; this includes new registrants themselves, midwifery educators, midwifery practices, hospitals, professional associations, and regulatory bodies. All stakeholders stand to benefit from the development of a more standardized approach to introducing new registrants into the midwifery profession. The previous chapter outlined the impact of clinical management, orientation, mentorship, and professional development on the transition to clinical practice.

As midwifery students are laying the foundation for their new registrant year, an essential component of the Building phase is their Preparation for clinical practice. Preparation is achieved through gaining exposure to a variety of clinical situations and having opportunities to experience clinical management. The midwifery practice where senior students complete their final year-long placement is highly influential in terms of both the clinical experiences and midwifery practice characteristics that students are exposed to. For example, students placed at a limited scope practice in their senior year may have less exposure to the management of oxytocin infusion for the augmentation or induction of labour and the management of epidural analgesia for intrapartum pain management compared to their peers who are placed at full scope midwifery practices. To provide another example, students who complete all

of their clinical placements in an urban center may have little or no understanding of the nuances and challenges related to midwifery in rural or remote communities. Both of these situations illustrate situations where graduating students may experience a gap in their knowledge or skills which could potentially limit the preparedness of students to practice midwifery in the diverse settings where midwives in Ontario work. Student placements are determined by lottery and offer students little control over elements of their placements such as scope of practice, urban or rural environment, or size and call schedule of midwifery practice. Examination of the MEP lottery system may be warranted in order to ensure greater consistency related to the characteristics of clinical placements for students over the course of the clinical placement portion of their education.

Also related to Preparation for clinical practice, the findings of this study highlight the importance of preparing for clinical management, and bring to light instances where midwifery students did not receive adequate opportunity to manage clinical care prior to graduation. Despite there being clear expectations of clinical competencies upon entry into midwifery clinical practice, for some individuals, their final clinical placement does provide adequate experience to integrate these core competencies into providing comprehensive care (2). As demonstrated in this study, the clinical preceptor's ability to step back and allow the midwifery student space to make clinical decisions independently impacts a students' experience in developing the skills necessary to managing clinical care. It may be valuable to revisit the competency milestones that senior students meet over the course of their final year and how competency related to clinical management is assessed. Additionally,

examining the training and ongoing support that clinical preceptors receive may help identify ways that midwifery practices and clinical preceptors can be better supported in allowing students the necessary independence during the final year of clinical placement to foster their Preparation for independent clinical practice.

In considering ways to meet the remaining three challenges to the transition to clinical practice – Orientation, Mentorship, and Ongoing Education – it is helpful to explore the models that other countries use to support new midwives in their transition to clinical practice. There are two primary models that are used to support the transition to clinical practice for midwives, each of which will be considered with respect to its' ability to meet the orientation, mentorship, and professional development needs of Ontario new registrants. The first model is a residency program and is often seen in jurisdictions where hospital-based midwifery is common, such as in Australia and the United Kingdom. The second model is a formalized mentorship program, such as New Zealand's Midwifery First Year of Practice (MFYP) program (56,82,83).

Residency models are typically hospital-based programs designed to facilitate the transition from student to clinician by providing education and mentorship to new nurses and midwives (84). The purpose of these programs is to encourage new graduates to develop their knowledge and skills in order to meet the demands of clinical practice (85). Residency programs often include assigned mentors who are trained in the unique needs of new graduates and whose role is to provide support and feedback to one or more new graduates (85). In addition to mentorship, residency programs provide formal orientation to the clinical setting. Programs may

involve pre-determined rotations through various clinical areas of the hospital, and often include education days specifically designed for new graduates (85). While the particular details of residency programs vary across jurisdictions, the role of the mentor is clearly defined and usually incorporates a formal selection, training, and evaluation process (85). Residency programs have been shown to lessen some of the stress associated with the transition to clinical practice, as well as improve job satisfaction and retention rates (84). In addition to these benefits, residency programs provide new graduates with the opportunity to become familiar with the clinical setting, develop interprofessional relationships, and offer the space and time for new midwives to learn and ask questions (80).

The second model to support the transition to clinical practice is a formalized mentorship model, as seen in the Midwifery First Year of Practice (MFYP) program in New Zealand (56,82,83). The MFYP program is a particularly interesting model to examine since the midwifery model in New Zealand is similar to the midwifery model in Ontario. As in Ontario, midwives in New Zealand provide primary, community-based care to a caseload of clients throughout pregnancy, labour, birth, and for six-weeks postpartum (86). In the MFYP program, mentors must opt-in, meet certain clinical practice criteria, and complete training workshops (56). New midwives select their own mentor and meet regularly over the course of their transition to clinical practice to discuss progress, professional goals, and ongoing learning needs (82). Interestingly, in the MFYP model, new midwives are encouraged to select a mentor outside their immediate clinical practice in order to avoid the negative consequences of power dynamics that may exist within a midwifery practice (82). The MFYP

program is relatively new; it was implemented in 2007, at which point participation was recommended, but not required, for all new midwifery graduates (83). Since 2015, and following successful implementation, the MFYP program has been compulsory for all new midwives entering the profession (83). Positive outcomes of the MFYP program include improved professional confidence of new graduates and increased retention of midwives beyond five years of practice (83).

In considering the primary needs of new registrants as defined by this study, a combination of the residency and mentorship models would help address the Orientation, Mentorship, and Ongoing Education needs of new registrants. In considering the orientation of new graduates, residency models are typically implemented by hospitals and may include introduction to the overall hospital institution, as well as exposures to a variety of relevant hospital departments (85). This emphasis on comprehensive orientation to a specific institution reflects the new graduate's need for familiarization with institutional policies and processes. Orientation within the Ontario midwifery context is multi-faceted; many Ontario midwives retain admitting privileges at more than one hospital in their community and thus new registrants require orientation to multiple institutions. Additionally, the midwifery practice itself presents a quagmire of logistics in terms of client bookings, clinic organization, call scheduling, off call time, and vacation planning. Despite the complexities involved in orienting new registrants, the residency model may provide an appropriate framework to address this need.

Formalized mentorship is valued in both residency and mentor models. Both models incorporate guidelines for the selection and training of midwifery mentors and

define clear expectations within the mentor-mentee relationship. The development of a more structured mentorship program was a need expressed by study participants and would certainly help new registrants in Ontario as they move through the Building, Bridging, and Being phases. One interesting feature of New Zealand's MFYP program is that midwifery mentors are not necessarily midwives who work in the same community as their mentees. While typically study participants described mentorship relationships with midwifery colleagues working in their same practice, having the option of having a midwifery mentor in a different community may be an ideal option for new registrants working in small practices with few midwives, or in situations where new registrants do not feel comfortable with their colleagues as mentors. Mentors from outside a new registrant's own midwifery practice have the additional benefit of not being a part of the power dynamics and perceived or actual hierarchy of the midwifery practice; concerns which were raised by participants of this study.

Finally, both residency and mentorship models demonstrate the value they place on ongoing education and professional development through requiring new graduates to have protected time off call for educational activities. The expectation of off call time for educational activities not only emphasizes the value of professional development, but it also prevents new midwives from needing to schedule or negotiate additional off call time (85). Professional development and educational opportunities highlight the need for new graduates to continue to expand their clinical and professional skills, provides a context for new graduates to connect with peers and colleagues, and fosters the development a professional support network (80,82).

The emphasis on ongoing education reflects this study's findings that professional development is valued by new registrants in Ontario, both for the education and for the professional support networks that are offered through engaging in such activities. Looking to both residency and mentorship models provides a framework from which to develop a curriculum of professional development and educational activities designed specifically for Ontario new registrants.

Both residency and mentorship models offer benefits that are transferable to the Ontario midwifery context and provide ways to meet the Orientation, Mentorship, and Ongoing Education needs of Ontario new registrants. The residency model emphasizes a comprehensive orientation to various aspects of clinical practice setting, exposes new midwives to various departments within the hospital, and facilitates interprofessional relationships. Given that residency programs generally operate in hospital-based midwifery contexts, the residency model alone may not be sufficient to meet the orientation needs of new registrants in Ontario, however may offer a starting point to consider the comprehensive orientation of new midwives. Considering the similarities between midwifery in New Zealand and in Ontario, the mentorship model, as illustrated through New Zealand's MFYP program, may provide a framework that is well suited to meet the unique mentorship needs of Ontario new registrants. Having the option of selecting a mentor who does not work within the mentee's community may help address some of the challenges for new registrants working in smaller practice, rural and remote communities, and for individuals who have challenging relationships with their midwifery colleagues. Finally, in both the residency and mentorship models, the emphasis on a core

professional development curriculum is something that could be implemented in the Ontario context as a means of facilitating professional development and connecting new registrants across the province.

6.2 Study Limitations

While there are a small number of Canadian studies examining topics related to new registrant midwives, none have sought to create a theory to describe the transition to clinical practice. This study was designed to include data from a diverse participant group, incorporating a wide range of experiences with the goal of creating a theory that is applicable to all new registrants. Although theoretical saturation was achieved with the sample size of thirteen interviews, it is possible that the Building, Bridging, Being theory cannot be generalized to all new registrants across the province. Additional feedback from a wider sample of new registrants, possibly through survey-based research, may be helpful in establishing whether the elements of this theory are applicable to the wider audience of new registrants, and may help to enhance the validity of the Building, Bridging, Being theory.

Considering the demographic data of the participants (Table 2 – Demographic Data of Participants), there are some ways that a more diverse participant sample could be obtained. For example, only one participant in this study was a graduate of Laurentian University, and there were no participants in this study whose scope of practice changed from full scope as a student to limited scope as a new registrant. So, while theoretical saturation was reached with the study sample, ensuring all

demographic data categories reflected the demographics of the new registrant population in Ontario may be beneficial.

Another aspect of midwifery practice that participants were not selected for was the call model in which they worked as a new registrant. Currently there is no research examining midwives' experiences of the various call models used across the province. It would be interesting to explore how the call model that midwives experience as senior students and as new registrants impact the various aspects of the Building, Bridging, and Being phases.

One final limitations of this study was that it focused only on the experience of new registrants in Ontario. This methodological decision was appropriate given the scope of this study and considering that the majority of midwifery graduates and practicing midwives are in Ontario. A larger study encompassing the experience of new registrants in other provinces across Canada would be similarly beneficial to determine whether the Building, Bridging, Being framework is transferrable to the various midwifery contexts across Canada.

6.3 Future Research Directions

The Building, Bridging, and Being theory offers a starting point for further research regarding the transition to clinical practice for new registrants. There are many directions that research in this field can take, using the various elements of the Building, Bridging, and Being phases as starting points.

The transition to clinical practice truly begins during the final year of midwifery education when midwifery students gain critical clinical experience and take on more

clinical responsibility under the supervision of their clinical preceptor. Given that clinical management during the final year of midwifery education has such a strong impact on the transition to clinical practice, further research exploring how to support clinical preceptors and senior midwifery students in developing their clinical management skills would certainly be relevant to the transition to clinical practice, particularly supporting students in the Building phase.

This study illuminated the variation across midwifery practices with respect to the orientation and mentorship that new registrants across the province receive. It would be beneficial to gain a more comprehensive understanding of the various ways midwifery practices across the province orient, mentor, and support new registrants during the first year of clinical practice. Along with this, exploring the barriers that both midwives and midwifery practice experience in supporting new registrants at their practice would help determine how to better support effective mentorship across the province.

Most hospitals and midwifery practices require new registrants to have a predetermined number of supervised births or clinical procedures when they begin clinical practice. The exact number of supervised procedures that are required is highly variable across midwifery practices and hospitals and it is unclear who determines these numbers, and what, if any, benefit a precise number of supervised procedures affords new registrants. An investigation into the rationale of a setting a particular number of clinical procedures may provide some insight into whether having a predetermined number of supervised procedures is, in fact, beneficial for

new registrants and whether there should be a more competency-based approach to supervising new midwives.

The final phase of the transition to clinical practice theory is the Being phase. During this phase, new registrants self-identify as midwives and have a sense of belonging within the wider midwifery profession. While there has been extensive literature regarding the stages of developing one's professional identity, it was beyond the scope of this study to fully explore the various professional identity theories (62). A comparison of established identity theories with factors influencing new midwives' sense of identity and belonging would facilitate a deeper understanding of the transition process for new registrants as it relates to the development of professional identity.

A program of research designed to examine the transition to clinical practice of new registrant midwives would help identify the strengths and weaknesses of the current system of transitioning midwives into clinical practice and determine future direction for research in this field. The ultimate goal of such a program would be to ensure that graduates of the midwifery education program are prepared for clinical practice and that new registrants across the province have access to consistent and effective support at the beginning of their midwifery career.

Finally, a comparison of the Building, Bridging, Being theory to other models of cognitive, emotional, social, professional, and clinical development within various health care fields is another direction of research related to the midwifery transition to clinical practice. Given midwives' unique clinical, professional, and ideological role within the health care system, analyzing the similarities and differences between

various transition to practice models would help determine whether a distinct transition theory is necessary for midwives or whether Ontario midwives follow a similar transitional process as other new health care professionals, despite their distinct place in the Ontario, and broader Canadian health care context.

6.4 Conclusion

The goal of this study was to develop a theory to help understand the transition to clinical practice for Ontario new registrants. The findings of this study are relevant to individuals who are invested in the transition to clinical practice including new registrants, clinical educators, researchers, midwifery practices, hospitals, professional associations, and regulatory bodies. The Building, Bridging, Being theory offers an understanding of the new registrant experience as individuals transition from student to clinician. Through examining the Building, Bridging, and Being theory and the Bettering theme, four key elements were found to be highly influential in facilitating the transition to clinical practice:

a) Preparation for clinical practice through the opportunity to experience clinical management during the Building phase
b) Orientation to midwifery and hospital logistics and expectations during the Bridging phase
c) Mentorship through the Building, Bridging, and Being phases
d) Ongoing Education during the Bridging and Being phases

The findings of this study highlight the strengths, shortcomings, and inconsistencies that exist for new registrants in Ontario with respect to these four elements through

the Building, Bridging, and Being phases. In order to ensure new midwives are prepared for and supported through the transition to clinical practice, it will be important for midwifery stakeholders to strengthen the capacity of midwifery as it relates to the four elements of Preparation, Orientation, Mentorship, and Ongoing Education. Looking to transition to practice models used in other jurisdictions, such as the residency model and the mentorship model, offer a framework to developing a system that meets the unique needs of Ontario midwives.

The Building, Bridging, Being theory helps clarify the complex interaction of the Clinical, Emotional, Practical, and Cultural factors that influence the transition to clinical practice. This theory provides a starting point for future research regarding the transition to clinical practice for midwifery in Ontario and is likely applicable to the broader Canadian midwifery context. Enhancing the Preparation, Orientation, Mentorship, and Ongoing Education of new midwives as they enter clinical practice will help to strengthen the midwifery profession as a whole and ensure the sustainability Canadian midwifery for the generations of midwives yet to come.

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Appendices

Appendix A - Recruitment Email

E-mail Subject line: McMaster Study – The Transition to Clinical Practice for New Registrant Midwives in Ontario

As part of a graduate program in Health Science Education at McMaster University, I am carrying out a study to learn how new registrant midwives in Ontario navigate the transition from student to clinical during their first year of clinical practice. The purpose of this study is to describe the process by which midwives transition from student to clinician, to reveal whether there are common experiences or challenges that all new registrants face in the year following graduation, and to determine whether or not the transition experience for midwives is similar to the experience of other health care professionals.

I am planning to conduct interviews with three groups of participants:
A. New registrants in their first year of clinical practice.
B. Midwives who have been practicing for 1-5-years.
C. Individuals who work closely with new midwives in a supervisor or mentor role.

Eligibility Criteria

- Participants in all three groups must be registered midwives in Ontario
- Participants in groups **A** and **B** must have graduated from an Ontario Midwifery Education Program
- Participants in groups **A** and **B** must not have worked as a health care professional in another field (e.g. – nursing, allied health, midwifery outside of Canada, etc.) prior to their career as a midwife in Ontario
- Participants in group **B** must have completed their new registrant year at an Ontario midwifery practice

How do I sign up?

- Please read the letter of information attached
- Visit our website: www.nrstudy.wordpress.com for additional details
- Complete a recruitment survey by following this link: https://www.surveymonkey.com/r/newregistrantsurvey
- After you complete the recruitment survey, I will contact you to answer any remaining questions you have,
- I will contact you by phone or email to answer any questions you have about this study and to arrange an interview time and location. Interview times and locations will be flexible based on your availability. Facetime and Skype interviews will be conducted in cases where in-person interviews are not possible.

I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the Hamilton Integrated Research Ethics Board (HIREB #11-409). If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

Hamilton Integrated Research Ethics Board
293 Wellington St N, Suite 102
Hamilton, ON
L8L 8E7
Telephone: (905) 521-2100 ext. 42608

Thank you in advance for your time and consideration.

Christine Sandor
RM, BSc, Masters Candidate - Health Science Education, McMaster University
sandor@mcmaster.ca
905-807-7484

Appendix B – Participant Demographic Data

Participant Group	□ A – New Registrant □ B – Midwives practicing < 5-years □ C – New Registrant Supervisor and/or Mentor
Full Name	
Telephone Number	
Email address	
Gender	□ F □ M
Age	
Profession prior to midwifery	
Location of midwifery education	□ Laurentian University □ McMaster University □ Ryerson University □ Université due Québec à Trois Rivières □ University of British Columbia □ University College of the North □ Mount Royal University □ IMPP □ PLEA □ Other (please specify):
Year of graduation from MEP	
Number of midwives in current midwifery practice group	
Current community of midwifery practice	Location: _____ □ Urban □ Rural □ Remote
Current scope of midwifery practice	□ Full-scope (oxytocin and epidural) □ Limited-scope – please describe:
Participant Groups A & B Only	
Community of midwifery practice as a senior student	Location: _____ □ Urban □ Rural □ Remote
Scope of midwifery practice as a senior student	□ Full-scope (oxytocin and epidural) □ Limited-scope – please describe:
During your midwifery education did you ever:	□ Have an extended clinical placement □ Receive a provisional pass for a clinical placement □ Repeat a clinical placement □ None of the above

Appendix C – Social Media and Website

Facebook
Web address: www.facebook.com/nrstudy
Short Description:
This study is aiming to answer the question: How do new registrant midwives in Canada navigate the transition from student to clinician?

Long Description:
Purpose of the Study:
The purpose of this study is to describe the process by which Canadian midwives transition from student to clinician, to reveal whether there are common experiences or challenges that all new registrants face in the year following graduation, and to determine whether or not this transition experience for midwives is similar to the experience of other health care professionals.

In an effort to gain a thorough understanding of this research topic I will be conducting interviews with three participant groups:
1 - New registrants in their first year of clinical practice
2 - Midwives who have been practicing for 5-years or less
3 - Individuals who work closely with new midwives in a supervisor or mentor role.

Procedures Involved in the Research:
If you are interested in participating in this project, the following will occur:
• You will complete an online recruitment survey to provide some initial demographic information.
• I will contact you by phone or email to provide you with some additional information about the study and to arrange an interview time and location. Interview times and locations will be flexible based on your availability. Facetime and Skype interviews will be conducted in cases where an in-person interview is not possible.
• The interview will last approximately 1-hour and, with your permission, will be audio-recorded for later transcription and analysis.
• You will be asked to describe your experience as a new registrant, or your experience working with new registrant midwives.

Ways to sign up: comment on this page, send me an email or message, follow *this link* to complete a recruitment survey.

Twitter
Account: @nrstudy
First Tweet: Now recruiting participants for a study looking at the experience of new registrant #midwives in Canada! [link to website]

Website
Address: www.nrstudy.wordpress.com

Website Pages:

New Registrant Midwives in Canada

This study aims to answer the question: How do new registrant midwives in Canada navigate the transition from student to clinician during their first year of clinical practice?

The purpose of this study is to describe the process by which midwives transition from student to clinician, to reveal whether there are common experiences or challenges that all new registrants face in the year following graduation, and to determine whether or not this transition experience for midwives is similar to the experience of other health care professionals.

In an effort to gain a thorough understanding of this research topic I will be conducting interview with three participant groups:

- New registrants in their first year of clinical practice
- Midwives who have been practicing for 5-years or less

Individuals who work closely with new midwives in a supervisor or mentor role.

Sign up by emailing me, leaving a reply, or follow this link to complete a recruitment survey.

About the Researcher

My name is Christine Sandor and I am completing this study as the thesis component of my Masters of Health Science Education at McMaster University.

I am a registered midwife and I have been practicing in Hamilton, Ontario since I graduated from McMaster's Midwifery Education Program (MEP) in 2010.

Study Purpose

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Through this study I hope to learn more about the experience of new registrants as they transition from student to clinician. I hope that what is learned as a result of this study will help us to better understand common experiences and challenges that new registrants face in their first year of clinical practice and determine whether systems could be put in place to better prepare students for clinical practice and to identify whether there is a need to better support new registrants during their first year of clinical practice.

Study Procedure

If you are interested in participating in this project, the following will occur:

- You will complete an online recruitment survey to provide some initial demographic information.
- I will contact you by phone or email to provide some additional information about this study and to arrange an interview time and location. Interview times and locations will be flexible based on your availability. Facetime and Skype interviews will be conducted in cases where in-person interview are not possible.
- The interview will last approximately 1-hour and, with your permission, will be audio-recorded for later transcription and analysis.

You will be asked to describe your experience as a new registrant, or your experience working with new registrant midwives.

Privacy and Confidentiality

Every effort will be made to protect your privacy and confidentiality. I will not use your name or any information that would allow you to be identified. I will be using quotes and situational examples during data analysis, however your personal information will be coded in such a way so that only I have access to the information linking your name to the data provided in your interview.

Your participation in this study is voluntary. If you decide to be part of the study, you can withdraw from the interview for whatever reason, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Appendix D – Interview Guide Sample

Group A: New Registrants

Research Question: ***How do new registrant midwives in Canada navigate the transition from student to clinician during their first year of clinical practice?***

Questions

1. How have you navigated the transition from student to clinician?
2. In what ways did your training as a midwifery student prepare you for clinical practice?
3. Are there any aspects of clinical practice that you feel your training did not adequately prepare you for?
    a. Are there any ways you feel you could have been better prepared for clinical practice?
4. How does your midwifery practice support new registrants during their first year of clinical practice?
5. What were your expectations regarding mentorship as a new registrant?
    a. Were these expectations met?
6. What aspects of your transition from student to clinician have you found particularly challenging?
    a. How have you dealt with these challenges?
7. What has helped facilitate transition to clinical practice?
8. What role has mentorship played in your transition to clinical practice?
    a. Can you identify a single person who you would consider a mentor during your first year of clinical practice?
9. Do you have any suggestions for how to improve the new registrant experience?

General Probes

1. How did you feel about the experience you described?
2. What will you take away from that situation?
3. What about this experience did you find particularly challenging/supportive/ troubling/helpful?

Closing Question

1. Do you have any other thoughts or insights related to the research question that you want to talk about that you haven't had the opportunity to discuss with me today?

"Tell me what you think about…"
"What happened when…"
"What was your experience with…"