Midwives transition to practice: Expectations and experiences

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TITLE PAGE

TRANSITIONING THROUGH FIRST YEAR OF PRACTICE: THE EXPERIENCES OF MIDWIVES WHO HAD BEEN EMBEDDED WITHIN A CASELOAD MIDWIFERY PRACTICE DURING THEIR UNDERGRADUATE MIDWIFERY DEGREE

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CONFLICT OF INTEREST STATEMENT

This manuscript and the study on which it is based is the original work of the authors. This data has not been analysed or published elsewhere and is not in the process of being considered for publication in another journal. We declare that the content of this paper is original; that each author meets the criteria for authorship as set out in the Author Information Pack and has seen and approved the manuscript being submitted. The study received ethical approval and we declare that no author has a conflict of interest.

ABSTRACT

The Rural Private Midwifery Education Program (RPMEP), a 2013 strategic response to midwifery workforce issues by the Queensland Government was unique in the Australian context. Midwifery students were embedded within a private midwifery caseload practice or rural publicly funded midwifery group practice (MGP). Continuity of midwifery care was at the core of the students' learning experience. This paper describes a study designed to explore the expectations and experiences of this group of newly qualified midwives as they transitioned to practice. Using a qualitative descriptive methodology, eight newly qualified midwives were interviewed. Thematic analysis was used to analyse the data set. Six themes were identified; 'Midwifery – an unexpected career path', 'The 'gifts' of being embedded in caseload as a midwifery student', 'No jobs - no real choice', The hospital system - A whole different world', 'Resetting (or Adapting) expectations - Drawing on what I know to be true' and 'What the future holds'. Transitioning to practice after being embedded in caseload midwifery as a student provided challenges for the newly qualified midwives. At the same time it 'gifted' them a strong commitment to woman centred care, continuity and a social model of maternity which they draw on to support their transition.

INTRODUCTION

Much has been written about the first year of practice of nurses and other health professionals, yet little is known about the experience of newly qualified midwives. Many of the limited studies available focus on the concepts of transition to practice support programs, mentoring, and retention of midwives within the profession. What has been published suggests that the evolution from student to qualified midwife is a challenging time. Newly qualified midwives must find their 'own feet' whilst experiencing a level of vulnerability, fear and professional

uncertainty as they accept responsibility and accountability for critical clinical decision making (van der Putten 2008, Clements et al. 2013).

Transitioning to specific areas of midwifery practice such as birth suite and/or working across the full scope of practice within publicly funded midwifery caseload models are a recurrent feature of published literature of newly qualified midwives' experiences (Clements et al. 2013; Cummins et al. 2015). A midwifery caseload model is where midwives provide continuity of care throughout pregnancy, are 'on call' for labour and birth and provide up to 6 weeks of postnatal care to a defined number of women (and their families) per year in an activity-based way (Cummins et al. 2015; Homer 2016). Little is known, however, about the newly qualified midwifes' expectations and experience of transitioning to practice having undertaken their entire undergraduate Bachelor of Midwifery (BMid) clinical placement within a midwifery caseload practice where all the women received continuity of midwifery care.

The aim of the study was to explore the expectations and experiences of a newly qualified group of BMid students who undertook their entire undergraduate clinical placement within a private midwifery caseload practice or an all-risk publicly funded rural midwifery caseload practice.

BACKGROUND

An integrative review of the literature using the structure developed by Whittemore and Knafl (2005) was undertaken to identify relevant knowledge about first year of practice expectations and experiences of newly qualified midwives. A search of the major databases CINAHL; Medline via EBSCOHOST; Ovid; PsycINFO; Proquest Nursing and Allied Health; Scopus; Health Reference Centre; and the Cochrane database was undertaken in February 2017. Six

papers met the inclusion criteria and were appraised for methodological quality using 'Critical Appraisal Skills Programme [CASP] Tool for Qualitative Research. All were deemed to be of high quality. Combined, the studies included 92 participants.

The major anticipated aims of the studies were varied. Clements et al. (2013); Hobbs (2012); Kitson Reynolds et al. (2014), focussed on the cultural and professional experiences of the newly qualified midwives. Cummins et al. (2015); and Fenwick et al. (2012) aimed to explore enablers and impediments to newly qualified midwives' transition to employment in caseload models and standard hospital models of maternity care. Lastly, van der Putten (2008) sought to inform midwifery educators of practice issues to be addressed when supporting student midwives preparation for transition to practice. Despite these differences there were some similarities in the findings of the studies.

Firstly, in all the studies it was evident that newly qualified midwives regularly experienced high levels anxiety and emotional exhaustion, due to increased responsibility, professional accountability, decision making, fear of failure and subsequent reprisal (Clements et al. 2013; Fenwick et al. 2012; Kitson Reynolds et al. 2014; van der Putten, 2008). Busy, chaotic clinical environments where the needs of the institution, task completion, routines and rules took precedence over the needs and care of women heightened this anxiety (Fenwick et al. 2012; Hobbs, 2012; Kitson Reynolds et al. 2014; van der Putten, 2008). The incongruence between their midwifery philosophy and beliefs and the reality of mainstream medicalised maternity care often culminated in tension, dissatisfaction with midwifery, frustration and feelings of resentment particularly when newly qualified midwives experienced pressure to relinquish their belief in normal birth and woman centred care in favour of institution-based care (Fenwick et al. 2012; Hobbs, 2012; Kitson Reynolds et al. 2014; van der Putten, 2008).

Commonly, the literature revealed, newly qualified midwives often found themselves in hostile and unwelcoming environments (Clements et al. 2013). Midwifery colleagues were often revered as custodians of power and influence over the newly qualified midwives' sense of professional and personal safety (Fenwick et al. 2012). Participants described being directly influenced by the moods and personal characteristics of the other midwives and the environment (Clements et al. 2013; Fenwick et al. 2012; Hobbs, 2012; Kitson Reynolds et al. 2014). The need to maintain and 'accept' the hierarchal nature of the clinical environment was commonplace and seemingly took precedence over the facilitation of learning consolidation and growth of newly qualified midwives into safe woman-centred autonomous practitioners (Clements et al. 2013; Hobbs, 2012; Kitson Reynolds et al. 2014). Not surprisingly, participants described a growing sense of frustration, isolation, and a declining sense of professional self-worth, confidence and competence (Fenwick et al. 2012).

Alternatively, positive attitudes, active engagement, compassion and role modelling of woman centred care were identified as characteristics of midwives who provided positive learning experiences (Clements et al. 2013; Cummins et al. 2015; Fenwick et al. 2012). Supportive, trusting and affirmative professional relationships were shown to positively impact the newly qualified midwives' feelings of competence and confidence to practice autonomously and provide quality woman centred care (Cummins et al. 2015; Fenwick et al. 2012; van der Putten, 2008). Evidence also exposed that placement within a caseload model during the transition period supported learning, created a sense of belonging and aided personal and professional development more frequently than where newly qualified midwives were placed in traditional fragmented models of maternity care (Clements et al. 2013; Cummins et al. 2015; Fenwick et al. 2012; Hobbs, 2012; Kitson Reynolds et al. 2014; van der Putten, 2008).

In summary, all the included studies discussed the experiences of newly qualified midwives as they transitioned through their first year of clinical practice. Very few participants, (n=11) had the opportunity to be employed within caseload models of midwifery care during their transition year. But where they did, newly qualified midwives reported feeling well supported and able to practice woman centred care that embraced the evidence and normality of birth. Few studies provided specific detail about the types of clinical experiences the newly qualified midwives were exposed to as a midwifery student and no studies explored the transition to practice after placement for all or the majority of their student clinical learning experience within a caseload model. This represents a significant gap in the literature.

STUDY CONTEXT

The RPMEP was a 2013 Queensland Government initiative funded by the Department of Health as a strategic response to midwifery workforce issues. A collaboration was formed between the Nursing and Midwifery Office Queensland (NMOQ), Griffith University and *My Midwives* a private caseload practice based in Queensland. The strategic intent of the project was to grow the midwifery workforce and to ensure newly qualified midwives were better equipped to work in continuity models of midwifery care, specifically in private practice midwifery and rural midwifery caseload models (Carter et al. 2015). Additional anticipated outcomes of the RPMEP included an exploration of an innovative midwifery education clinical placement model relative to the current, predominant model of brief time limited rotations through different clinical areas in a fragmented and inflexible way (Carter et al. 2015). Recruitment of students to the program was led by NMOQ for graduate nurses, with an interest in women's health and/or maternity, who were unable to find full-time employment in the year following the completion of their Bachelor of Nursing (BN) degree (Carter et al. 2015).

Grounded in a philosophy of woman centred care, the RMPEP embedded each student either within a private midwifery caseload practice or a rural publicly funded midwifery group practice for the two years of their full-time BMid degree. This enabled continuity of midwifery care to be at the core of every clinical placement learning experience (Carter et al. 2015).

Midwifery student's experience of clinical placement in this model is unique in the Australian context. Initial work to evaluate the program was undertaken by (Carter et al. 2015) who reported that students perceived this model of clinical placement as highly beneficial to learning, promoting confidence and competence. It is now timely to explore the expectations and experiences of these newly qualified midwives as they transitioned to practice.

RESEARCH DESIGN

Methodology

Qualitative descriptive methodology was considered an appropriate method for this study. It offered a valuable means of deriving direct and honest accounts of the nature of the everyday experience of the newly qualified midwives as they transitioned through their first year of practice unencumbered by theoretical or philosophical standpoints (Holloway and Wheeler, 2017).

Participants and recruitment

Following ethical approval, the 17 midwives who completed their BMid as part of the RPMEP were invited to participate. Eight midwives demonstrated interest in the study and consented to be interviewed by telephone.

Data Collection.

Semi-structured digitally recorded telephone interviews were used to collect data. A set of open ended prompting questions were developed to guide the interview process (see Box 1). Given the varied location of participants across Queensland, telephone interviews were considered the most appropriate means of data collection as they offered convenience, flexibility and privacy (Cachia and Millward 2011). Field notes were also recorded during and after the interviews. On average the interviews lasted between 45-60 minutes and were transcribed verbatim.

Data Analysis

Thematic analysis was used to analyse the data set. The data was broken down into discrete units and organised into clusters of like words and phrases. Using a constant comparative approach, data was continuously compared and refined to eventually form themes and/or subthemes. As the 'like' groups became saturated with data possible links between groups were explored. A mapping processes was used to assist with this process. The pattern, which was eventually made up of six themes, represented the phenomena of the midwives' expectations and experiences of the first year of practice. The process of developing the themes was a shared endeavor to enhance the credibility of the research findings (Holloway and Wheeler 2017).

FINDINGS

Participant Characteristics

The eight participants in this study were all female aged between 18-34 years (mean = 27 years). All participants lived and worked in Queensland and were employed in full-time (n=2)

or part-time (n=5) positions in rural, regional or tertiary hospitals within six months of their BMid graduation (see Box 2).

Themes

Being embedded in continuity of care and caseload midwifery during their BMid degree provided unique challenges for the newly qualified midwives during their first year of practice. The six themes that emerged from the data are described below.

Midwifery - an unexpected career path.

Midwifery was an unexpected career path for all participants in this study. All participants entered RPMEP not being able to secure employment at the completion of their BN degree. The participants also described varying degrees of exposure to midwifery, for example, *'I didn't really think about birth or anything until I started studying midwifery'* (M4). Although not being well versed on the role and function of a midwife, most participants approached the opportunity in a pragmatic way and saw the completion of the program as means of enhancing their employability and skill set. One midwife expressed;

> *'I truly thought at the time that it was just – I couldn't get any jobs as a grad as a nurse, so I just thought this is a bit of an extra string on my bow and a sidestep nearly, as just something extra to have to try and maybe get me a job'* (M7).

Others expressed positivity about their experience in caseload midwifery. For many the program ignited a '*passion*' for midwifery. For example, one midwife said; *'I loved all of my experiences with the private midwives. I think it was the best thing that I could ever have done'* (M5).

The 'gifts' of being embedded in caseload as a midwifery student

Being embedded within a caseload midwifery model afforded the midwives a highly valued and rich learning environment. Discovering the art and science of midwifery, whilst constantly wrapped in continuity, ingrained in the midwives the capability to see everything through the eyes of the woman. The sustained exposure of working with different women, in different settings, across different locations, in a partnership approach with their mentor, was perceived to enhance communication skills and the midwives ability to establish rapport. In turn, they talked about learning the importance or '*power*' of informed decision making and advocating for women. The consequence of working in this way contributed to their tenacity and resilience with one participant verbalising; '*You have to be able to advocate, speak up and say I'm not happy, - this isn't right or whatever. I think that's made me stronger'* (M8). Being adaptable and independent with an increased awareness of community resources were also attributes gained by working in caseload. Finally, consistently working across their full scope, being part of the woman's entire childbearing journey, including the transition to motherhood, meant the midwives came to appreciate the longer-term ramification of decisions and care provided and what this might mean for an individual woman and her family.

> *'I feel gaining most of my experience in continuity of care was the best way to learn about midwifery because I followed women across the continuum – I was able to see the effects of interventions and how they played out for women. I was able to view everything from a woman-centred perspective. You see the outcomes of the interventions as well, so it was a really valuable learning experience for me'* (M4).

No Jobs - No Real Choice

As they approached the completion of their degree, participants recalled feeling confident, ready for practice and keen to transition into a midwifery position within either a public or

private caseload model. However, the participants found that there were no midwifery positions available to them in the caseload model. This situation was compounded by the lack of legislative support for newly qualified midwives to work to the full extent of their qualification as private practice midwives. For example, while one midwife did commence in private practice she said the restrictions on what she could and could not do were unworkable resulting in her leaving.

> *'It was particularly challenging because of the Medicare eligibility requirements. I had to have supervision all the time... I couldn't even do home visits without anyone. Not only was that annoying for me but for the women as well. I was obviously having to visit them either really early in the morning or really late at night just to accommodate other midwives'* (M1).

The paucity of jobs resulted in most participants applying for a number of diverse and different positions. Compelled to seek employment further afield than private midwifery practice, expectations changed, and new ones emerged. Within months of completing their degree all participants had gained employment.

Lost in the system – a whole different world.

Accepting a position within the public hospital system was considered a necessary compromise. The new reality of being a hospital employed midwife was considered '*daunting*' and accompanied by an array of emotions such as *'terrified',* and *'very nervous'.* Despite these feelings, the midwives initially felt confident about their ability to undertake this adjustment. However, as they settled into their new reality, working in a fragmented hospital system was found to be far more difficult and different than anything they had anticipated. The following

quote is reminiscent of all participant's experiences; *'I expected it to be challenging and different, but it was a massive shock and so much harder'* (M6).

The midwives' limited exposure to working within a hospital shift-based model was initially considered a *'disadvantage'*. Early in their transition the participants conceptualised their new working environment as *'another world'*. They found the ways of working when employed in large public hospital organisations, such as taking care of a *'patient load'* in shifts and completing task focussed care, within restrictive timeframes, extremely challenging and incredibly '*foreign*'. As their experience in caseload midwifery was one of working in partnership providing individualised woman centred care to one woman at a time, within a supportive mentor by their side, a lack of ongoing relationships with women and the inability to witness and/or be part of the outcome of their care proved disheartening; 'So *you just go to work, you do your hours and you go home. You don't see the end. You don't know what happened'* (M8).

The level of complexity and degree of intervention, irrespective of the clinical area in which they worked, was also initially challenging; *'Those interventions, that was probably the hardest part to come around to, and the expectation that I was just going to do that. So, it was dealing with accepting that'* (M7). Participant's spoke of feeling '*overwhelmed*' and even though they considered they had the '*knowledge*' they questioned their ability and skill set. Feelings of inadequacy were heightened by a sense of '*being watched'* and their perception that some colleagues did not fully trust they could provide the appropriate level of care and expected them to '*underperform*'. As one participant recalled: *'Lots of people had their doubts initially. It was almost like they were waiting for you to fall on your face, and then scoop you up again. But I like to think I didn't fall on my face'* (M2).

Finally, it was the dissonance between the participant's midwifery beliefs and their experiences of working in a fragmented and medicalised system that was most disorienting. As students, the midwives had '*lived and breathed*' a woman centred primary focused evidenced based approach to care within a continuity midwifery model. Being faced with care that they perceived lacked these features was distressing; *'I struggled with coming into a system where woman centred philosophies, birth is normal and informed decision making are not necessarily valued'* (M4).

Finding my way: drawing on what I knew to be true

As their first year of practice drew to a close the midwives described how they had commenced the process of '*re-setting*' their expectations focusing less on the challenges they had experienced and more on how they could work in a positive way with each and every woman, as commented by one participant;

> *'You can break your heart over it and feel disappointed and feel ripped off and think that women are not getting a good deal, or you can say okay, this is what I've got to work with and how can I make it the very best for the women that I've got for those short hours'* (M8).

The lessons learned from being embedded within a continuity model during their degree became key at this point. The midwives realised providing continuity had afforded them many 'gifts' which they could contribute to the care of women regardless of the context they were in. For example, one midwife said;

> ‘*I found that rather than looking at the women as patients and tasks it was more beneficial to actually go - I can still kind of bring continuity into this and to get to know their families and work with them for the short time they’re there’* (M6).

All the midwives felt their clinical experiences within the caseload practices had provided them with a strong identity as a midwife. As the midwives settled into their new environment they drew on their midwifery core values and the attributes afforded them to manage their diverse experiences. The following sentiment was common in the dataset;

> *‘I remember thinking that it wasn't about changing the hospital system, it wasn't about trying to get around the change, it was doing it in a way that fitted my own philosophy and my own ideas and how I wanted to midwife basically. Fitting my way of being a midwife around the structure of the hospital’* (M7).

What the future holds

As the interviews drew to a close, participants were guided to consider their future midwifery career. Overwhelmingly, participants indicated their plan to remain in midwifery with most expressing an unwavering commitment to continuity of care and a desire to work in caseload; *‘Continuity is something that I'd like to move back into’* (M2). However, despite the challenges most midwives acknowledged the learning they had gained across their first year of practice and for the short term were content to continue in their current roles.

> *‘I think I would like to stick around at this hospital for a little while longer. I feel that there’s still a lot more I need to learn. But definitely going back to my local area and doing more of the continuity of care, being a caseload midwife in the next few years is probably my goal’* (M6).

DISCUSSION

This study has provided insight into the first year of practice expectations and experiences of midwives who were embedded within caseload midwifery for their undergraduate midwifery degree. Unfortunately, upon graduation, and in contradiction to their expectations, employment within a public or private caseload model was lacking. Having little choice most midwives gained employment within mainstream non-caseload services. Transitioning from student to registered midwife within the foreign environment of shift based medicalised maternity care left midwives feeling out of their depth and experiencing dissonance between their core midwifery values and philosophy and the way they were expected to organise and deliver care to women in a fragmented system. Initially, this resulted in the newly qualified midwives experiencing a sense of culture shock that left them feeling overwhelmed, despondent and lost. However, the midwives soon learned to draw on the many 'gifts' that studying in continuity had bestowed on them to provide quality woman centred care no matter what the context.

Culture shock

Irrespective of chosen profession it is reported that beginning health practitioners experience a turbulent and often daunting journey of feeling discouraged and underprepared in environments that are often viewed as unwelcoming and unsupportive, culminating in low levels of professional confidence, self-doubt and anxiety (Ortiz 2016). In midwifery specific literature, newly qualified midwives having experienced traditional models of clinical placement report feeling overwhelmed and burdened by conflicting ideologies between their formal learning and the reality of their new work environment (Fenwick et al. 2012; Kitson Reynolds et al. 2014). The midwives in this study were no different experiencing a 'crisis of confidence' which was further compounded by feeling underprepared for the ethos, nuances and organisation focussed standpoint of fragmented institution based maternity care. Impacting their feelings of

professional safety upon entering the 'system' were the attitudes and expectations of the midwives with whom they worked. For several participants a dichotomy existed between those registered midwives in their workplace that expected them to perform at a higher level when compared to peers with a more traditional pre-registration clinical placement experience and those midwives who believed they were not prepared well enough for their hospital-based role. A sense of being 'outsiders' combined with feeling constantly judged, the participants feelings of self-confidence and sense of belonging were eroded overshadowing their transition to practice experience. The new midwives perceived that a lack of understanding about caseload midwifery bred distrust affecting working relationships between themselves and their colleagues. The loss of deep connections and partnerships they had been used to experiencing with women and their mentor midwives during their student caseload placement only worked to heighten feelings of distress and disillusionment.

Supporting transition: Lessons from embedded continuity

The value of caseload midwifery as an instrument of learning for midwifery students has not yet been well defined. For the midwives in this study, their clinical learning within caseload practice gifted them a resounding and steadfast focus on, and commitment to, the needs and experiences of the women for whom they provided care. Significantly, this led to a strong sense of responsibility and accountability for ensuring informed decision making and woman centred care in their beginning midwifery roles.

As the new midwives' confidence improved they gradually came to 'accept' that the system was overwhelming and to survive and grow as professionals they needed to think carefully about how and when to respond. Drawing on their deep connection with women and commitment to informed choice, the newly qualified midwives, successfully responded to the

organisational model of fragmented maternity care by transforming routine practices and task-based care into opportunities for empowerment, informed choice and woman centred care. Hunter (2004, p. 320) refers to this as "covert autonomy" and Kirkham (1999, p. 736) as "doing good by stealth". By honouring and staying close to their philosophy the midwives perceived they were able to effect positive change for women entrusted to their care. Taking this approach, the new midwives were able to make work satisfying and eventually culminated in midwives feeling more accepted within the work environment, strengthening their sense of fitting in. As authors such as Crowther et al. (2016) and Hunter and Warren (2014) have alluded to, the trust the new midwives had in women, and the power of the midwife-woman relationship, were used as effective coping strategies to overcome a way of working that challenged everything they knew and believed about midwifery.

Barriers to moving straight into caseload models

For all participants in this study, placement in a midwifery caseload practice for their entire clinical practice program ignited a passion for woman centred care and revealed a deep desire to work in this model upon graduation. However, their options were limited by a lack of employment opportunities within public caseload models as well as legislative restrictions on entering private practice.

Despite the evidence of the benefits of continuity of midwifery care for women, babies and midwives reorientation of mainstream services to increase continuity models has been slow (Fenwick et al. 2018; Perriman and Davis 2016; Sandall et al. 2016). A 2013 cross-sectional survey of Australian maternity services identified that only 31% offered caseload midwifery with less than 10% of women being able to access this type of care (Dawson et al. 2016). It is therefore not surprising that most of the newly qualified midwives in this study were

unsuccessful in their ambition to gain a position within a caseload model of midwifery care

Significant legislative barriers also exist. These prevent newly qualified midwives moving into private practice upon graduation even though upon registration they are considered equipped to provide care to women as accountable, autonomous practitioners with the requisite skills and knowledge to meet the requirements of the Nursing and Midwifery Board of Australia (NMBA) Midwife Standards for Practice (Nursing and Midwifery Board of Australia 2018). To move into private practice midwives are requried to 1) undertake 5000 hours mandated clinical practice experience within a six-year timeframe, 2) complete an additional qualification leading to endorsement to prescribe scheduled medicines, and 3) fulfil the evidentiary requirements that address the NMBA Safety and Quality Guidelines for Midwives (Nursing and Midwifery Board of Australia 2017), including a collaborative arrangement with an obstetrician. Any midwife working in a private practice that does not meet these requirements must be supervised in all aspects of the care she or he provides childbearing women (Nursing and Midwifery Board of Australia 2016a, 2016b, 2017).

Most other health professional groups have the freedom to choose to enter private practice upon graduation. For example, registered physiotherapists, and dentists, are free to establish themselves as independent practitioners based on meeting the requirements of their initial qualification with evidence of professional indemnity insurance and recency of practice. Recency of practice for these health professional groups varies from an undefined number of hours in the preceding five years for dentists to 150 hours in the last 12 months or 450 hours in three years for physiotherapists (Dental Board of Australia 2015; Physiotherapy Board of Australia 2016). This contrasts significantly to the 5000 hours (equivalent of three years full time clinical practice) that midwives are required to achieve if they want to access to the

Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), both of which are required to enter private practice. There is little doubt this is a major hurdle to transitioning to private practice for newly qualified and/or early career midwives. Again, there are dissimilarities between health professional groups. For example, graduates with a medical degree are given access to Medicare provider and PBS prescriber numbers when undertaking their first year of supervised practice as an intern without general registration as a medical practitioner (Medical Board of Australia 2012).

Limitations

While offering a new and unique perspective, the findings do need to be interpreted within the limitations of the study. The small number of participants means generalisation is not possible. For example, exploring registered midwives' experiences of working with the newly qualified midwives would have provided additional insight. Having said this, these findings add to the growing body of work on continuity of midwifery care.

CONCLUSION

This small but insightful qualitative descriptive study adds to knowledge surrounding the first year of practice transition experiences of newly qualified midwives. After being embedded within a caseload model for most of their clinical practice experience the midwives in this study graduated feeling confident and well prepared to work across their full scope. All wanted transition into practice as registered midwife within a caseload model. Opportunities to work in this way, however, were limited both within the public and private sector. These new midwives are key to the professions ability to reorientate maternity services to ensure all woman, regardless of risk, can access midwifery led care within a supportive multidisciplinary team. New midwives must be supported to transition straight into caseload models for which

they are well prepared. It is also time to seek regulatory change to the current legislation that prevents newly qualified midwives from working in private midwifery practice.

Further research inquiry in this field would contribute to the growing body of evidence that supports the educational preparation of midwives to work across the full scope of their practice in partnership with women.

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Tables and Figures

Table 1.
Summary of appraised articles

Author/Title	Study Design/Setting	CASP Appraisal
1. *Hobbs, J. (2012)* *Newly qualified midwives' transition to qualified status and role: Assimilating the 'habitus' or reshaping it?*	*DESIGN:* Qualitative ethnographic approach *SETTING:* West Country UK, major maternity department	**Include** *CASP* **10/10**
2. ***Clements, V., Davis, D., & Fenwick, J. (2013)*** *Continuity of Care: Supporting New Graduates to Grow into Confident Practitioners*	*DESIGN:* Qualitative descriptive explorative design – part of a larger study *SETTING:*14 public maternity hospitals in Sydney, Australia	**Include** *CASP* **9/10**
3. ***Cummins A. M, Donney-Wilson, E. & Homer, C.S.E. (2015)*** *The experiences of new graduate midwives working in midwifery continuity of care models in Australia*	*DESIGN:* Qualitative descriptive design *SETTING:* A variety of clinical settings across Australia - tertiary hospitals 'to' stand-alone birth centre midwifery CoC models of care in NSW	**Include** *CASP* **10/10**
4. ***Fenwick, J., Hammond, A., Raymond, J. Smith, R., Gray, J. Foureur, M., … Symon, A. (2012)*** *Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their transition to practice*	DESIGN: Qualitative descriptive design SETTING: Participants from one hospital in metropolitan Sydney	**Include** *CASP* **10/10**
5. ***Kitson-Reynolds, E., Cluett, E. & Le-May, A. (2014)*** *Fairy tale midwifery—fact or fiction: The lived experiences of newly qualified midwives*	*DESIGN:* Interpretive phenomenology research process. *SETTING:* A number of National Health Service Trusts across the UK	**Include** *CASP* **9/10**

Box 1: Promoting Questions

1. Can you share with me what your expectations for your first year of practice as a newly qualified midwife before you commenced employment were?

2. Tell me about your experience as a student midwife in the RPMEP program.

3. Tell me how you have found your first year of practice experience

4. Can you share with me what you consider were the greatest influencing factors on how you experienced your first year of practice?

Box 2: Participants Workplaces

Participant	Workplace Note: One participant obtained a position in a private midwifery practice initially, and later transitioned into a hospital-based position but is not specifically identified here to maintain her confidentiality
1.	Working in regional hospital
2.	Working in Regional Hospital – grad program rotating through all areas
3.	Working in large tertiary hospital – rotating through all areas before moving to a team midwifery model and then into a midwifery group practice.
4.	Working in rural hospital
5.	Working in large tertiary hospital – grad program
6.	Working in large tertiary hospital – rotating through birth suite and postnatal
7.	Working in large tertiary hospital – rotating through birth suite and postnatal
8.	Working in large tertiary hospital