Mentoring and New Zealand midwives: a survey of mentoring practice amongst registered midwives who are members of the New Zealand College of Midwives 2005

Sarah Stewart
PhD student
Centre for Online Health
University of Queenland
Brisbane

School of Midwifery
Otago Polytechnic
Dunedin
03 4793641
sarahs@tekotago.ac.nz

Richard Wootton
Professor of Online Health
Centre for Online Health
University of Queenland
Brisbane

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I would like to thank all the midwives who answered this survey. Many midwives went out of their way to put a lot of time and thought into their answers. Some have volunteered to take part in further discussions and research – I will take up their kind offers in the future.

Introduction
There are a number of issues facing NZ midwives that need to be addressed, such as the recruitment and retention of midwives; increasing medicalisation and rise in intervention rates which impacts on midwifery practice and the development and maintenance of skills; support of new graduates and sustaining rural midwifery (Holland, 2001; Patterson, 2000; Surtees, 2004). In its role of leader of the profession, the New Zealand College of Midwives (NZCOM) has developed a strategic plan for the next two years, with one of its priorities being to "strengthen the midwifery workforce"(New Zealand College of Midwives, 2004). The strategic plan has included the development of a mentorship framework, believing that mentorship is necessary "to enable midwives to maintain and develop their practice in a manner consistent with Standards for Midwifery practice". Before a mentoring framework can be developed it is important to carry out an analysis of what is currently happening in New Zealand (NZ). Thus, a survey was carried out in early 2005 to find out what midwives' thoughts are about mentorship, and what their experience has been both as mentor and mentored midwife.

This research is also the first stage of a PhD project, which aims to develop an online intervention that will facilitate the mentorship relationship between midwives in New Zealand.

Background
Mentorship has come to describe a relationship between mentor and mentee that encourages growth and development in a respectful and collegial environment (Vance & Olson, 1998). There are difficulties with the concept of mentorship because of the

different perceptions of what it is. In midwifery and nursing there appears to be confusion between mentorship, preceptorship and clinical supervision, with the roles interchanging (Dancer, 2003; Neary, 2000). Preceptorship has been defined as an experienced practitioner working with a new graduate as she develops competence and comes to terms with working in the 'real' world (Morton-Cooper & Palmer, 2000). The term 'new graduate' usually refers to the first year of midwifery practice (Wiegert Cuesta & Bloom, 1998). A preceptor is usually chosen to work with the new graduate in the clinical environment for a specified amount of time, and is often organised as part of a formal institutional orientation program (Hom, 2003). Whereas in a mentorship relationship, the mentee may be at any stage of her professional career and will probably choose her own mentor for reasons other that clinical teaching and the relationship will be long term (Fawcett, 2002; McKenna, 2003). Supervision takes places when a skilled practitioner works with another practitioner to observe, assess and advise in order to promote the development of professional skills (Morton-Cooper & Palmer, 2000). In NZ the application of mentorship appears to be a mixture of supervision, preceptorship and mentorship.

The current situation in NZ

The New Zealand College of Midwives has a guiding consensus statement on mentoring (New Zealand College of Midwives, 2000). There are no other national frameworks or guidelines about how and where the mentoring arrangement should take place. Moreover, there is no formal payment system in NZ, except what is arranged between the mentor and mentee, although it has been suggested by that mentors' performance will be enhanced by financial rewards (Hurst & Koplin-Baucum, 2003).

At the time of writing this report there was little evidence as to what is actually happening in NZ, so most information about mentoring is anecdotal. Mentoring appears to be regarded as mostly necessary for new graduate midwives, with two models of mentoring. One involves a high degree of surveillance by the mentor who physically attends all births up to a certain number, which is an enduring feature from the days when access agreements made these requirements. The other model is a much less formal

arrangement, meeting away from the clinical environment and may include electronic communication such as telephone or e-mail.

Access agreements

The conception of mentorship in NZ came about following the 1990 Nurses Amendment Act (Holland, 2001). This Act enabled midwives to become autonomous practitioners and care for pregnant women without the supervision of doctors. Direct-entry midwifery degree education programs followed in the early 1990s. Access agreements were developed by hospitals, which articulated restrictions on new graduates or midwives returning to practice. These agreements varied from hospital to hospital but many developed requirements of supervision for a specified number of births (National Women's Hospital, 1995). Recent changes have seen the development of a national, generic access agreement which is attached to Section 88 Maternity Notice (New Zealand Ministry of Health, 2002). There is no mention of mentorship or supervision and makes no requirements of new graduates. Similarly NZCOM makes no reference to new graduates in its latest consensus statement on mentoring, and supports the idea of classic mentorship relationship with no defined program and is an "enabling relationship in personal, emotional, organisational and professional terms"(New Zealand College of Midwives, 2000).

Benefits of mentoring

Midwifery and nursing literature has focused on mentorship in the hospital setting, looking at the effect on employed staff. Mentoring assists the mentee to develop personal and professional relationships in the clinical setting, and decrease social stress (Hurst & Koplin-Baucum, 2003). This has been shown to aid practitioners to increase their confidence and improve clinical skills (Theobald & Mitchell, 2002). Mentoring helps the mentored practitioner to problem-solve and learn from her reflection so that she can face particular clinical challenges (Dancer, 2003; Northcott, 2000). Mentorship increases staff retention and improves job satisfaction, and has been utilized as a strategy for addressing staff shortages, especially in minority groups such as minority ethnic groups (Greene & Puetzer, 2002; Smith, McAllister, & Snype Crawford, 2001). Practitioners have found mentorship to be a useful tool for career development especially at the beginning of their

career and at specific defining moments such as a change of work role including moving from clinical practice to education (Barnard, 2002; Brockbank & McGill, 1999; Vance & Olsen, 1998).

Aims

Before strategies or interventions can be put into place to foster an environment of mentoring, it is vital to find out what is happening in NZ because currently there is little information about what midwives are doing or what they favour as a feasible model with regard to mentorship. The research question is how midwives in New Zealand consider the concept of mentorship. The other aim is to find out about the experience of midwives who have either been a mentor or mentored midwife.

Method

Design

The design was a descriptive survey using an anonymous postal questionnaire. A pilot study was carried out to test the questionnaire design and method of analysis. The researcher and NZCOM developed the questionnaire collaboratively (Appendix One). The National Committee of NZCOM, which includes Maori representation, was consulted during the collaboration process. A pilot study was carried out to test the questionnaire and method of analysis. The questionnaire was made up of 33 questions, nine of which were open questions. The remaining questions were closed, although 14 of them invited respondents to write 'other' comments. The questionnaire took 10-20 minutes to complete, depending on the respondents' experiences and how much they wanted to divulge. The questionnaire was made up of four sections. The first section asked for personal demographic information. Respondents were asked about their opinions of mentoring in section two. In section three, respondents were asked about their experiences of being a mentor, and in section four, respondents were asked identical questions about their experiences of being mentored.

Data analysis

The data generated from the questionnaire is nominal. Descriptive statistics were employed to analyse the data utilising the Statistical Package for Social Science (SPSS).

Sample

The sample was a convenience sample of registered midwives who were active in practice in NZ, who belonged to New Zealand College of Midwives and who gave permission for their contact details to be released (n=1577). The first batch of questionnaires was sent out in November 2004 with the NZCOM Journal. It soon became evident that there were midwives who had not received a questionnaire. This was a result of a distribution error. Nevertheless, 387 questionnaires were returned. A repeat post out in January 2005 resulted in a further 297 responses. Thus, the final response rate was 44% (n=684/1577).

A limitation of this study was that it did not survey the total population of practising midwives in New Zealand (NZ), which was 2282 in 2004 (New Zealand Health Information Service, 2004). Whilst the results of this study cannot be generalised to the whole midwifery population, the survey was applied to the majority of midwives in NZ.

Ethical considerations

The survey was anonymous with no identifying markers. Several participants identified themselves in order to volunteer to help with further research, or ask for a research report. That information was kept confidential and not included in data analysis. Ethical consent was obtained from one of the human ethics committees of the University of Queensland, Brisbane, in accordance with Australia's National Health and Medical Research Council's guidelines (National Health and Medical Research Council, 1999). Questionnaires were distributed by NZCOM to its membership. The researcher did not have access to names or addresses.

Results

Demographics

Respondents were most likely to be self employed Lead Maternity Carers (LMCs) (n=334/684, 49%) practising in an urban setting (n=480/684, 70%); they were mainly European (n=519/684, 76%) and had been practising for five to14 years (n=249, 36%)

Table 1. Missing data resulted when respondents either did not answer the question or when they gave more than one answer, which made their response invalid.

Table 1. Demographics of the respondents

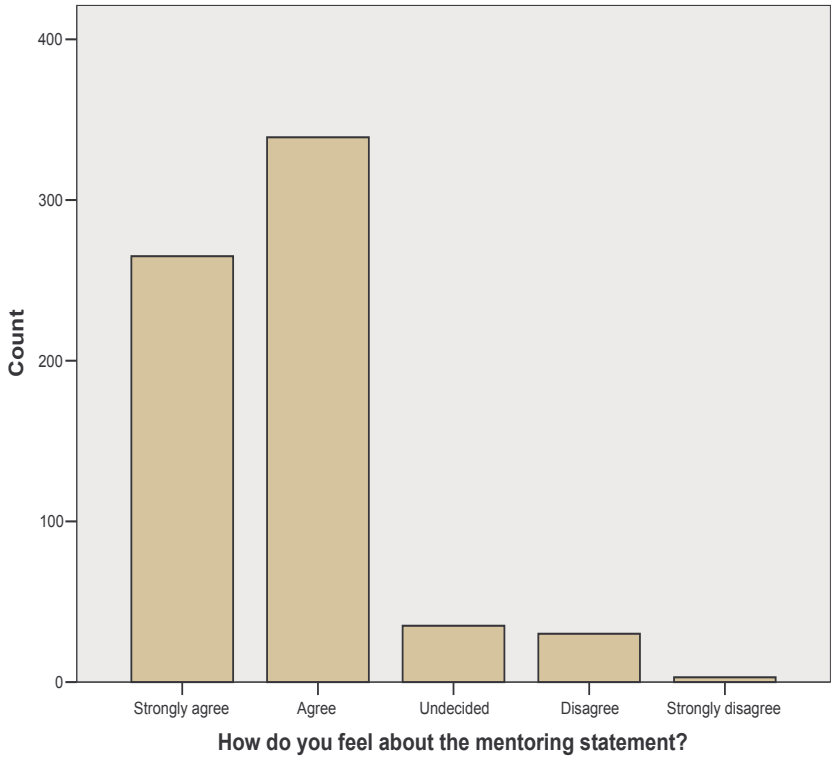
Main job	**n**	**%**	**Years of practice**	**n**	**%**
Core	167	24	Less than one	30	4
Employed LMC	100	15	1-4	112	16
Self-employed LMC	334	49	5-9	126	18
Research	2	0.3	10-14	123	18
Lecturer	16	2	15-19	74	11
Manager	26	4	20-24	93	14
Not practising	15	2	25-29	49	7
Missing	24	4	30-34	45	7
			35 and over	24	4
			Missing	8	1
Total	*684*	*100*	*Total*	*684*	*100*
Ethnicity			**Main setting**		
NZ European	519	76	Urban	480	70
NZ Maori	33	5	Rural	153	22
Samoan	4	0.6	Remote	15	2
Cook Island Maori	1	0.1	Missing	36	5
Niuean	2	0.3			
Other Pacific	4	0.6			
Chinese	5	0.7			
Other	100	15			
Missing	16	2			
Total	*684*	*100*	*Total*	*684*	*100*

Opinions of mentoring

The majority of respondents either agreed (n=339/684, 50%) or strongly agreed (n=265/684, 39%) with the NZCOM Consensus Statement (NZCOM, 2004) about mentoring (Figure 1.)

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

Figure 1. How midwives feel about the NZCOM consensus statement about mentoring



Respondents were invited to write comments [identified in this report by italics] if they disagreed with the consensus statement, which was then sorted in themes. The themes included an expansion of the statement to include competence.

> *I think the purpose is more that just developing competence. It is also an aid to developing competence within a safe relationship & allows experience to develop.*

There was a difference of opinion as to whether mentoring should be a formal arrangement. Some felt it should be a formal arrangement, with a structured format including time limits and signed contracts between mentored and mentored midwife. Others felt that mentoring should be an informal arrangement according to individual needs.

I agree with the above statement however I believe there needs to be a more structured framework to the mentoring relationship

The mentoring arrangement must be specific. A contract must be implemented to allow participants boundaries. The roles and responsibilities of both supervisor/supervised must be spelt out. A contract must be signed. The mentor must meet the required standard of professional knowledge in order to put herself forward as a mentor

It is hard to define as individuals are so different. Much of the above statement is correct but I don't believe all mentorship relationships can be placed in a box

The above statement is a very formal type of mentoring not always available. Sometimes mentoring is more informal - not needing to take up as much of the mentoring midwives' time. Necessary in some rural remote areas

A number of respondents wrote about the importance of mentoring for new graduates especially if they were LMCs.

However I feel new LMCs need to be mentored to protect the new midwife, the women she cares for and the reputation of our profession

I would like to see more defined role of mentor to support new midwife through any difficult situations, be readily (always or a substitute) - available to talk through or assist

Needs to be in a non-threatening manner. Must be built on trust. New grad needs to feel that the mentor is there for her. In my case my whole mentoring was dreadful experience

Achievement of mentoring

Respondents were mostly likely to think mentoring could be achieved through formal pre-arranged meetings (n=516/684, 75%); informal meetings when the need arises (542/684, 79%), face-to-face contact in the clinical setting (n=580/684, 85%); face-to-face contact away from clinical setting (n=523/684, 77%); or by telephone (546/684, 80%) Table 2.

Table 2. How mentoring could be achieved

How mentoring can be achieved	n	%
Formal, pre-arranged meetings	516	75
Informal meetings when the need arises	542	79
Face-to-face contact in clinical setting	580	85
Face-to-face contact away from clinical setting	523	77
Hui/marae based meetings	140	21
Telephone contact	546	80
Fax	102	15
Mail	76	11
Email	212	31
Video-conferencing	75	11
Internet chat	82	12

Respondents felt that the arrangements for the achievement of mentoring should be flexible and reflect the individual needs of the mentor and mentored midwife.

> *All avenues that are conducive to open reflection, and under the surface discussion for exploration and learning to be achieved*

> *Each midwife is different some need more formal face-to-face contact, others don't. Need to decide together what will work best. Overall most important is being accessible*

There were respondents who felt that mentoring should be carried out with some sort of physical presence of the mentor.

> *I really feel all forms of communication are vital but you must have face to face and also a formal arrangement*

> *I think the mentor needs to be available i.e. close by to be able to attend births/ or incidents where a midwife may require a mentor. Debriefing after the event could take place via e-mail but for 'hands on' or advice the mentor needs to be around*

> *If I am mentoring I want to see how the person practices.*

Barriers to being a mentor and being mentored

The most likely barriers to being a mentor were a lack of time (n=554/684, 81%); lack of training (n=378/684, 55%); financial constraints (n=316/684, 46%). Respondents wrote that the negative attitudes of the mentored midwife were a barrier to being a mentor.

Lack of honesty, openness. Overconfidence & lack of skills of mentee

Lack of value placed on "older sharing with younger". Belief we should "know" when we qualify - not believing in process

The experience and attitudes of the mentor was a barrier.

Main barrier is a lack of commitment to support other practitioners

Previous bad experience [of being a mentor]

Maybe not finding a midwife you really 'click' with to mentor

Another barrier was the lack of guidelines about mentoring.

Lack of mentoring guidelines. Insufficient standards for outcomes. Hit and miss approach currently inadequate and confusing for all

Lack of professional commitment to mentoring through appropriate selection, training, support & policy/standards

The most likely barriers to being mentored were unavailability of mentor (n=439/684, 64%); financial constraints (n=312/684, 46%); lack of time (n=297/684, 43%). A number of respondents believed that being unable to find a mentor with a similar midwifery philosophy.

Finding a mentor with same midwifery philosophy i.e. based on midwifery not obstetric practice

A further barrier to being mentored was the attitudes of the mentored midwife in that she did not know she needed to be mentored.

Have been told that when they qualify they do not need to be supervised

My experience has shown that a new grad midwife is not in a position to negotiate terms and structure. She doesn't know what she needs and often finds it difficult to ask for help.

As midwives we are always learning. New midwives come out of training encouraged to feel confident & capable - a midwife is a midwife is a midwife (relating to the new midwife being fully trained) but we all know midwifery skills are developed after a long period of practice

Being told they do not need a mentor as they are better trained than the 'older' experienced midwife trained prior to 1991 etc

I personally have noted that some midwives don't actually recognise the benefits of having a mentor - no insight

The final barrier to being mentored was a lack of professional and institutional support.

Lack of formal agreement, requirements of mentorship from NZCOM.

Lack of support from College - this should be compulsory requirement of practice

As core midwife, mentoring is not organised with us for this to happen

Role of the mentor

Respondents considered that the role of the mentor was mostly to provide professional support (n=662/684, 97%); a safe environment for the mentored midwife to reflect on her practice (n=626/684, 92%); hands-on clinical support (n=554/684, 81%); provide hands-on clinical teaching (n=457/684, 67%); negotiate clear roles and responsibilities for both midwives (n=420/684, 61%). Further to the questions provided, participants added that the role of the mentor was to teach and encourage clinical skills at the mentored midwife's request, as well as provide practical help and support.

Also to teach/assist with the things you missed out on your training or had little experience with eg: booking, instrument inductions on your own, assisting with forceps/ventouse, suturing, organising hospital based opportunities and referrals

Provide hands on support only in exceptional circumstances when the need arises

Fostering the reality that midwifery is in fact a lifestyle on its own, and will at times, not necessarily be compatible with other lifestyles, roles, responsibilities and will necessarily have to take priority

Support new midwife in a sometimes hostile environment - from other health professionals

Another aspect of the mentor's role is to encourage the mentee to reflect on her practice, as well be available to share knowledge and give advice.

Mentor's main role is of support. Giving the other midwife opportunities to reflect and make decisions on their own professional grounding

Provide feedback: how the midwife practices. Shares knowledge not found in books/articles etc

There are various important qualities that a mentor should have, including the ability to be truthful, honest and non-judgmental.

To be unconditionally supportive/accessible and non-judgemental

Be open to learning new perspectives from the mentored midwife

Honesty, diplomacy, and not discussing shortcomings with other midwives in delivery suite

Responsibilities of mentor and mentored midwife

The responsibilities of the mentor were be committed to the mentoring relationship (n=659/684, 96%); be a good communicator (649/684, 95%); be respectful to the mentored midwife (n=636/684, 93%); non-judgemental (599/684, 86%); be an experienced midwife (n=586/684, 86%); have the ability to work in partnership with women (570/684, 83%); have a commitment to the development of midwifery practice (554/684, 81%); be a reflective questioner (571/684, 84%); be readily available (531/684, 78%); know the maternity service well (n=524/684, 77%). The respondents also articulated various clinical responsibilities such as respecting the midwife's scope of practice, yet making sure the mentored midwife is safe in her practice and making time for her.

To uphold our ethical responsibilities such as being guardians of the normal birth process and hold, value and respect for midwife's scope of practice

The obligation to step in and suggest a better idea if the midwife appears on the brink of making a serious mistake

Share responsibility in care of poor outcomes

Reduce own workload to some degree to allow time for mentorship role

Mentors also had professional responsibilities such as being confidential, resolving

conflict in a positive manner and providing constructive criticism. However respondents felt there should be guidelines about the responsibilities of a mentor.

> *I don't mean training specifically, just guidelines to help work from*
>
> *There should be clear guidelines outlining a commitment to a new midwife*

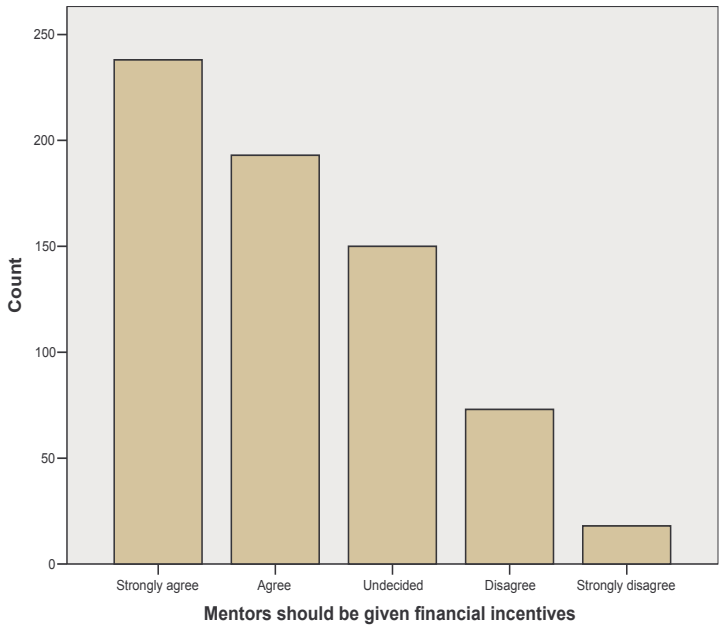
The responsibilities of the mentored midwife are to be committed to the mentoring relationship (n=656/684, 96%); negotiate clear roles and responsibilities for both midwives (n=555/684, 81%); identify the issues she wants to address (n=624/684, 91%); expect to be challenged on issues affecting her midwifery practice (n=592/684, 87%); expect to be challenged to identify her strengths and weaknesses (n=580/684, 85%); honour the agreed relationship and role boundaries (602/684, 88%); actively listen to mentor's advice and discuss any reservations (n=610/684, 89%); remain accountable for her own practice (655/684, 96%). Respondents felt it was important for the mentored midwife to be open and honest with her mentor as well as being committed to the midwifery model of practice and calling for help when she is outside her scope of practice.

> *Seek clarification when unsure of appropriate procedure/management. Respect mentor's personal/practice responsibilities*

Financial incentives

When asked if midwives should be given financial incentives to be a mentor, respondents mostly strongly agreed (n=238/684, 35%) or agreed (n=193/684, 28%) Figure 2.

Figure 2. Mentors should be given financial incentives



This question was a closed question, however respondents added that they agreed that mentors should be paid a financial incentive.

> *I have worked in a mentoring role with two new grad midwives. Financially I was not rewarded - through choice, as the new grad would not have been able to survive herself without a reasonable income - but I will not mentor again without some financial assistance from somewhere*

> *I feel strongly that mentors should be paid. As a new grad you need to feel that your mentor is available 24hrs/7days if you need her (or a back up mentor if she is having time off). At time of deciding if I needed her or not, the fact that I was paying her often helped me make that decision, if I hadn't been I would have felt bad waking her or calling on her days in a row. I would not have used her to her full potential if she wasn't paid*

There were some respondents who believed that mentoring should be a professional arrangement rather than a financial one, whilst some felt it should be negotiated on an individual basis.

Financial incentives may help compensate for time spent but this alone will not make an excellent mentoring relationship. It is not a financial transaction but a collegial contract

Individual agreement between midwives. If midwifery is a relationship of partnership, then $ remuneration should not be expected. Up to individual midwife to negotiate how all aspects of mentoring relationship will function

There were concerns that paying a mentor was too much of a financial burden for the mentored midwife.

I paid a lot to my mentor! We had a written and signed formal agreement and she attended all my births in the 1st year (1996). The financial aspects caused me stress/problems the following year because I didn't allowing for taxes etc. However, my mentor said the money was the incentive to get out of bed in the middle of the night! Financial incentives should not be crippling for the new grad LMC

I think only small remuneration to value professional input by mentor - shouldn't be so much that it inhibits new midwife from getting a reasonable income

A number of respondents agreed that mentors should be compensated but the funding should be provided by other sources other than the mentored midwife.

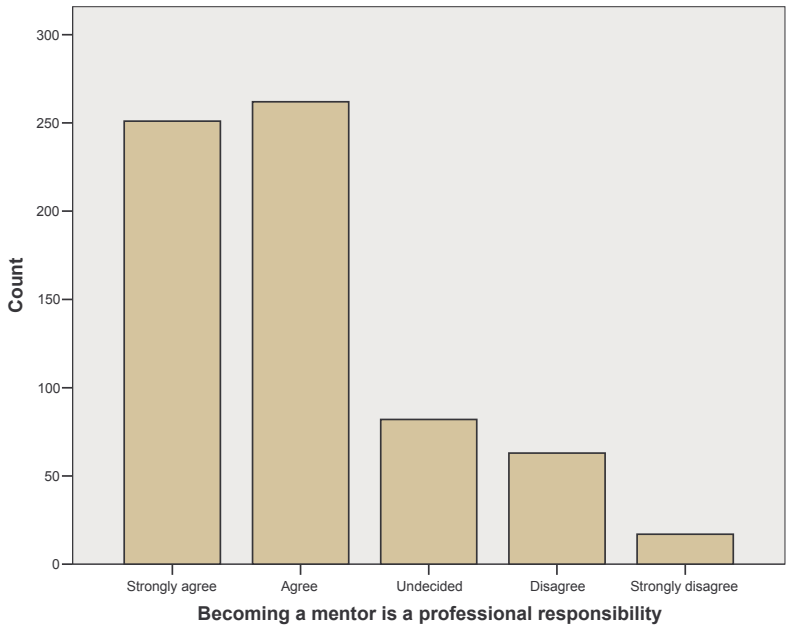
I don't agree that the mentored midwife should pay but I strongly agree that mentors should be paid for their services. The cost of mentoring (if covered by the mentee) is huge, especially after three years of no income while training and the expenses of setting up a new practice. Funding should be available to mentees through either NZCOM or MOH. At least a mentoring scholarship should be available to be applied for!

The only incentive to be a mentor in NZ is the commitment to midwifery. It involves a financial, professional, time commitment that needs to be more than an informal relationship with little recognition. Good mentoring is essential to ensure new midwives cope well with the transition. In my opinion, it needs to be financed with the College assessing the mentors and ensuring the money has been well spent with regular thorough independent checks

Professional responsibility

Respondents mostly strongly agreed (n=251/684, 37%) or agreed (n= 262/684, 39%) that mentoring was a professional responsibility (Figure 3).

Figure 3. Becoming a mentor was a professional responsibility



This question was closed question, but again respondents wrote explanations to clarify points. Some agreed that being a mentor was a professional responsibility but that it should not be compulsory.

> *I have been a part of a very beautiful mentorship, of immense value to me, a treasure in my heart. Hence my passion, and my belief in mentorship as integral to midwifery. Mentoring is so important, it might be worth writing a thesis on ways to support midwives to have/be mentors. REQUIRING it of them is not one of them.*

Others felt that midwives should not be mentors if they did not have the ability or desire to be a mentor

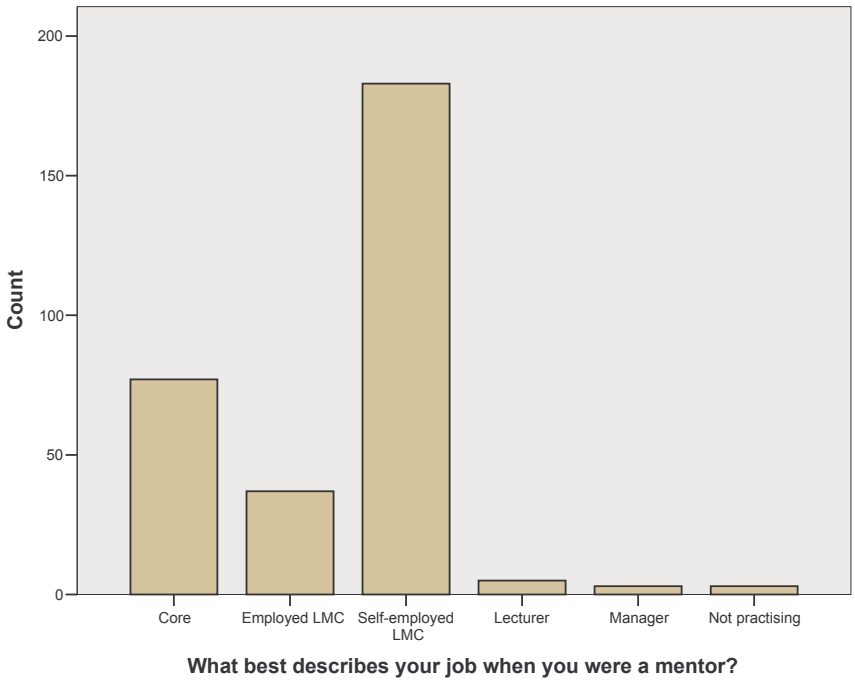
> *Need to have interest in doing it. Be suitable in temperament, personality etc just as not everyone is suited to teaching/tutoring*

The experience of a being a mentor

The respondents were asked about had been a mentor. Of 684 participants, 350 (51.2%) had been mentors and 323 (47.2%) had not. The main reasons why respondents had not been mentors were because they had not been asked (n=62/323, 19%) or because they had not been registered long enough (n=62/323, 19%).

The major reasons for being a mentor were to share knowledge (n=267/350, 76%) and to work collaboratively (195/350, 56%) Table 3. Respondents who had been a mentor were mostly self-employed LMCs (n=183/350, 52%) and core midwives (n=77/350, 22%) Figure 4.

Figure 4. Job when respondent was mentor



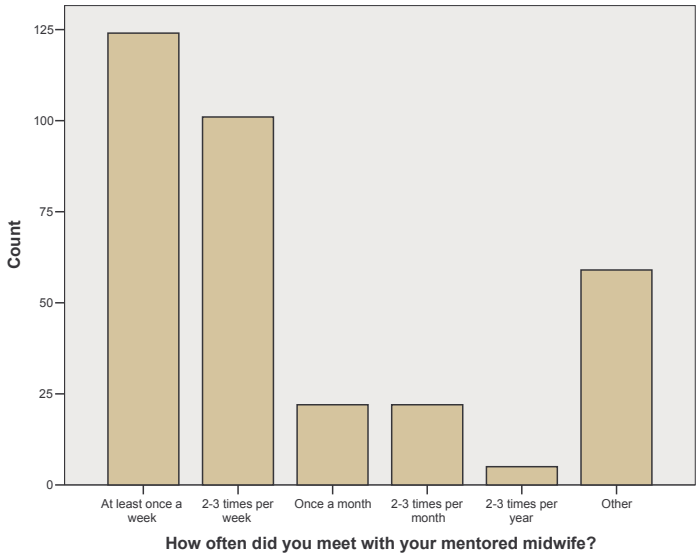
Respondents were asked what arrangements were made for management of workload/caseload Table 3. The most common arrangements for mentors were to reduce or restrict their workload/caseload (n=80/350, 23%), or share mentoring arrangements with another mentor (n=52/350, 15%). Mentors communicated with their mentees informal meetings when the need arise (n=275/350, 79%); face-to-face contact in clinical setting (n=301/350, 86%); face-to-face contact away from clinical setting and telephone contact (n=254/350, 73%).

Table 3. The experience of a being a mentor

Reasons for being a mentor	**n**	**%**	**Arrangements with mentored midwife for workload management and availability**	**n**	**%**
Personal career development	92	26	No change	48	14
Develop interpersonal communication skills	54	15	Reduced workload/caseload	80	23
To share knowledge	267	76	Available to attend births	30	9
To work collaboratively	195	56	Shared between more than 1 midwife	52	15
To attract another midwife into my practice	99	28	Worked the same roster/duties as mentee	20	6
Required by my employer	69	20	Specific time was set aside for meetings etc	39	11
To support new graduates	22	6	Arrangements made according to need	32	10
Worked with mentee as student	7	2	Available by phone	24	7
Believed it was a professional responsibility	13	4	Mentor shared workload/caseload with mentee	32	9
Other reasons	16	5	Mentee had to fit in with mentor's arrangements	13	4
			There were other arrangements	38	11
Communication with mentored midwife	**n**	**%**	**Reasons for no longer being a mentor**	**n**	**%**
Formal, pre-arranged meetings	217	62	I continue to be a mentor at present	63	18
Informal meetings when the need arises	275	79	The mentor or mentee changed jobs/location	51	15
Face-to-face contact in clinical setting	301	86	Conflict with mentee	9	3
			Too much of a commitment	16	5
Face-to-face contact away from clinical setting	231	86	Too much of a time commitment	46	13
			Too much of a financial commitment	17	5
Hui/marae based meetings	13	4			
Telephone contact	254	73	I required a break from mentoring	4	1
Fax	6	2	I am focusing on other professional activities	5	1.4
Mail	11	3			
E-mail	28	8	Mentee no longer required mentoring	68	19
Video-conferencing	1	0.3			
Internet 'chat'	3	1	There are other reasons why I am no longer a mentor	35	10

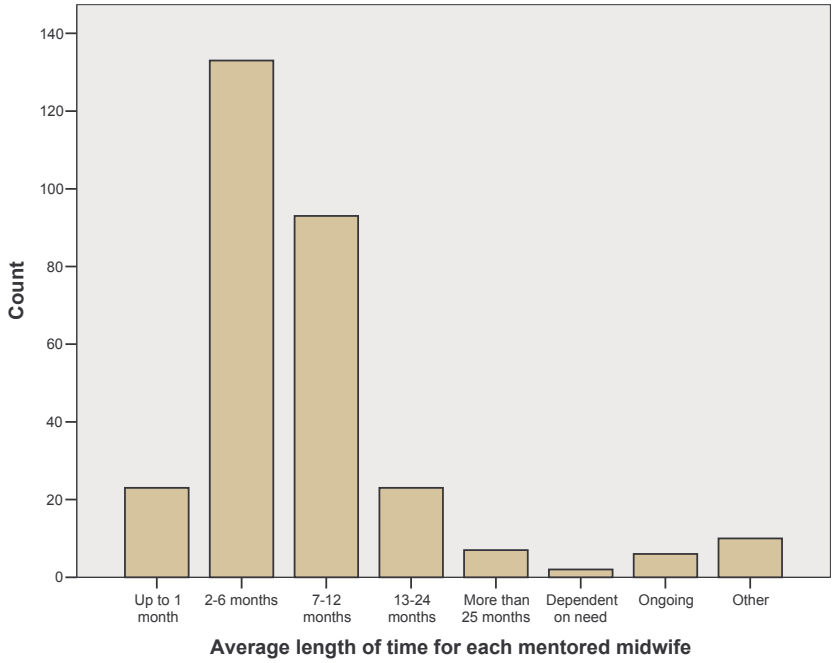
Mentors were most likely to meet with the mentored midwife at least once a week (n=124/350, 35%) and two to three times per week (n=101/350, 29%) Figure 5. This question however does not capture the fact that a number of respondents replied that their meetings became less frequent as time went by.

Figure 5. Frequency of meetings with mentored midwife



The average length of time they mentored each midwife was two to six months (n=133/350, 38%) and seven months to one year (n=93/350, 27%) Figure 6.

Figure 6. Average length of time with mentored midwife



The main reasons for no longer being a mentor were that the mentored midwife did not require mentoring any more (n=68/350, 19%); the mentor or mentored midwife changed jobs or location of practice (n=51/350, 15%); too much of a time commitment (n=46/350, 13%). Sixty-three (18%) respondents continued to be a mentor.

The experience of being mentored

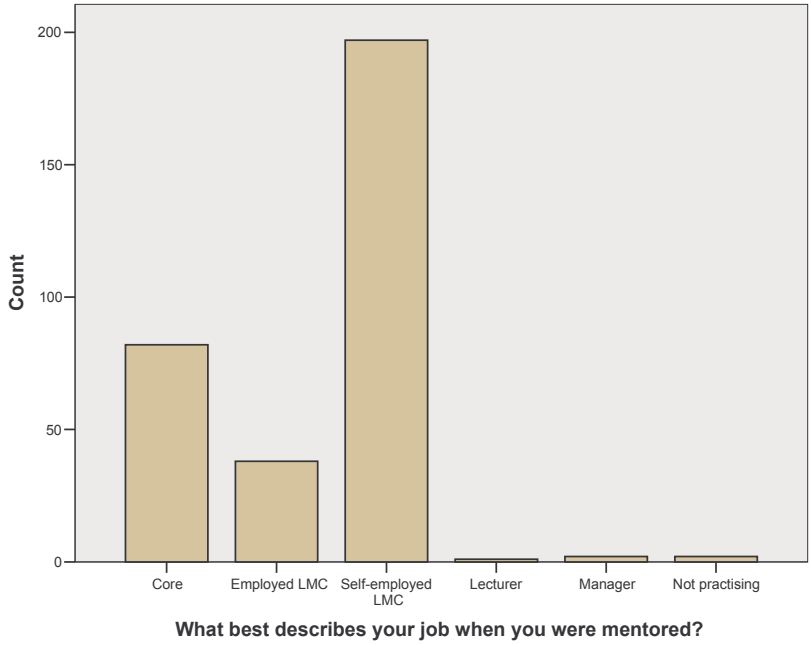
Respondents were asked if they had ever been mentored. About half the respondents had been mentored (n=349, 51%) and 307 (45%) respondents had not been mentored. The main reasons for not being mentored was that they had never had the opportunity (n=106/307, 35%), or they received all the support they required from their peers and colleagues (n=82/307, 27%). Being a new graduate LMC was identified as the most common reason for being mentored (n=185/349, 53%); change of role (n=68/349, 18%); new graduate working as core midwife (n=48/349, 14%); new to NZ practice (36/349, 10%) Table 4.

Table 4. The experience of being mentored

Reasons for being mentored	**n**	**%**	**How midwives choose their mentor**	**n**	**%**
I was a new graduate working as LMC	185	53	I had a relationship with her when I was a student	147	42
I was a new graduate working as core midwife	48	14	She worked in the same group practice	110	32
I was new to NZ practice	36	10	She worked in the same area	149	43
I returned to practice	20	6	Mentoring scheme was	83	24
I had a change of role	68	18	provided by employer		
I had a change of location	13	4	I respected her midwifery	195	56
I moved into a non-clinical role	10	3	practice		
I was working with women from a different culture	11	3	She had the same midwifery philosophy as I did	161	46
			She was a friend	76	28
			I felt 'safe' with her	176	50
			She was from the same culture as me	52	15
			Other reasons	15	4
Arrangements with mentor for workload management and availability	**n**	**%**	**Communication with mentor**	**n**	**%**
No change	20	6	Formal, pre-arranged meetings	145	46
Reduced/restricted caseload or workload	98	20	Informal meetings when the need arises	283	81
Mentor attended births	32	9	Face-to-face contact in clinical	278	80
Had more than one mentor	7	2	setting		
Worked the same roster/duties as mentor	23	6	Face-to-face contact away from clinical setting	210	60
Specific time was set aside for meetings etc	45	13	Hui/marae based meetings	9	3
			Telephone contact	255	73
Arrangements were negotiated according needs	37	11	Fax	9	3
			E-mail	15	4
Mentor was available by phone	16	5	Internet 'chat'	1	0.3
Mentee paid mentor	1	0.3			
Mentee shared workload/caseload with mentor	48	14			
Mentee had to fit in with mentor's arrangements	15	4			
There were other arrangements	28	8			

Respondents who had been mentored were mostly self-employed LMCs (n=197/349, 56.4%) and core midwives (n=82/349, 23.5%) Figure 7.

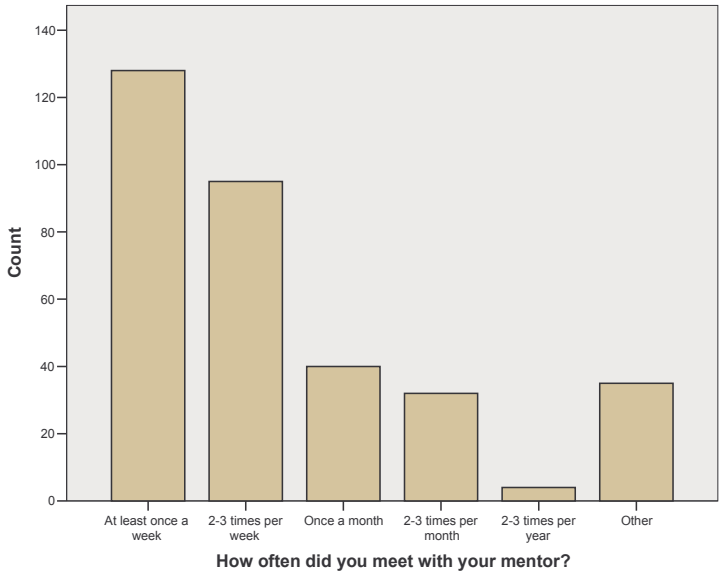
Figure 7. Job when being mentored.



Midwives choose their mentor for a variety of reasons including a respect of the mentor's midwifery practice (n=195/349, 56%); felt 'safe' with her mentor (176/349, 50%); had the same midwifery philosophy (n=161/349, 46%); worked in the same area (n=149/349, 43%) or had a relationship with the mentor when a student (n=147/349, 42%).

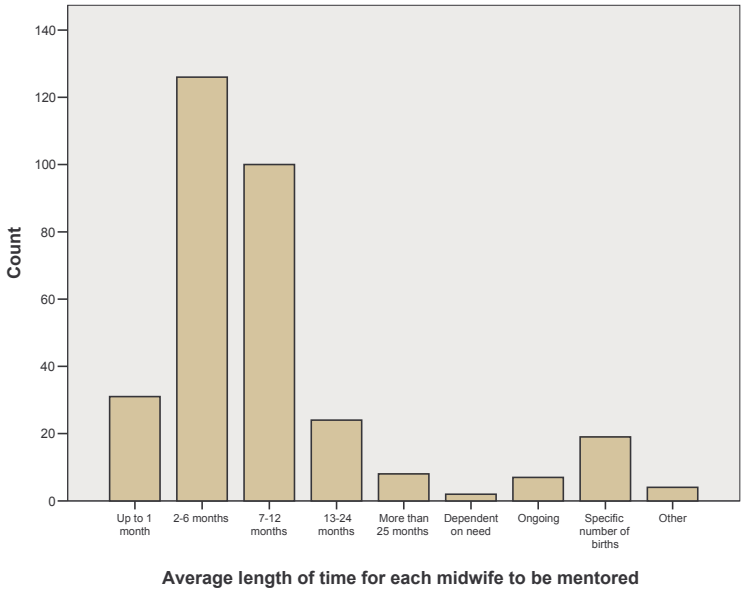
The most common arrangements were for the mentored midwife to have a reduced or restricted workload/caseload (98/349, 20%); specific times were set aside for meetings, debriefing etc (45/349, 13%); shared workload/caseload with mentor (n=48/349, 14%) Table 4. Communication with the mentor mostly took place in informal meetings when the need arose (283/349, 81%); face-to-face contact in clinical setting (n=278/349, 80%) and by telephone contact (n=255/349, 73%). Respondents were most likely to meet the mentor at least once a week (n=128/349, 37%) or two to three times per week (n=95/349, 27%) Figure 8.

Figure 8. Frequency of meetings with mentor.



The average length of time the respondents were mentored was most commonly from two to six months (n=126/349, 36%), or seven months to one year (n=100/349, 29%) Figure 9.

Figure 9. Average length of time with mentor



Respondents cited a number of reasons as to why they were no longer mentored which were sorted into themes and analyzed with SPSS. The foremost reasons for no longer being mentored were that they were confident enough not to require a mentor any more (n=158/349, 45%), and some were still in an informal supportive relationship with mentor (71/349, 20%).

Further comments

Despite the fact that this research was in essence a quantitative analysis of the experience of midwives and mentoring, some respondents added written annotations and accounts that were not canvassed by the questionnaire, yet they reflected the comments already made. Some wrote about their experiences of being a mentored, for which for some was very positive.

> *I could never have been independent without her support, commitment and unwavering kindness & friendship*

> *I feel mentoring is essential. It gave me time to consolidate all the learning I had done. Unlike as a student, I was responsible for all the decision making and it was great to have a colleague to contact at anytime if the need arose*

For some respondents, the experience of being mentored was not so helpful.

> *Relationship with the mentoring midwife broke down - she was not available when I needed her was unwilling to support me - I terminated relationship and began the mentoring relationship with another new grad - this was far more valuable than being mentored by an experienced midwife*

> *I did not feel she was available enough which made me feel insecure. I really feel that if I had a different mentor, I may have stayed as an LMC*

A few respondents wrote about their experiences of being mentors, which was mostly positive.

> *As I was mentored as a new graduate midwife I have felt the professional responsibility to "repay" that back to the profession by mentoring others*

> *By being available for the newer midwife in our practice, I am not only enhancing theory work, but enhancing my business too*

However, one respondent found it to be a harmful experience.

> *However it did not go well as the midwife being mentored did not call me when she was in the clinical setting. Her skills were not evolving despite encouragement and she was putting myself and my partner (midwifery) into situations of medico-legal vulnerability. We were advised by the College of Midwives' lawyer to withdraw from the mentoring relationship, which we did. This experience made me very wary of being a mentor again.*

The financial aspects of mentoring continued to be an issue for midwives.

> *I think mentoring is something we do badly in NZ - especially as a new grad it was very difficult to set up - I think I was very lucky in the end. Most of the people I trained with weren't able to find someone who would be available or willing without asking for a substantial sum of money*

> *I don't know if this is relevant but I do hear a lot of new grads reluctant to call upon mentors due to the money issue. I guess a lot of mentors expect a large sum of money to do this which is unfair on new grads. A small fee is acceptable - just a footnote of interest*

Other respondents wrote their opinions of mentoring. Some felt that mentoring should be valued because it is a means of sharing knowledge and professional development.

> *I think midwives working together and sharing skills, knowledge, thoughts, worries, experiences etc etc are mentoring and being mentored all the time. An enjoyable and essential part of midwifery practice.*

> *Mentoring is a state of mind and all midwives should value the exchange of knowledge and learn key teaching*

Another theme was the importance of mentoring for new graduate midwives, especially those who are LMCs.

> *I feel very strongly that new grads need a period of mentorship and that it is unethical starting up independent practice without a 'hands on' mentor. I would be very concerned if my sister/daughter/friend was cared for by a new grad with no mentor.*

> *New graduate LMC's are very vulnerable - they don't know what they don't know. They deserve to have much more structured mentoring arrangements where mentors have training and accountability*

> *I feel all new grads should have opportunity to be mentored. Currently I have seen that the availability of willing mentors is very very low and needs to be*

developed/encouraged. I also believe experienced midwives or returning to practice need this opportunity. Good luck

Very little was said about the need for mentoring of midwives working in a hospital setting

I think it is important all trainee new grad midwives are mentored in the hospital setting. It also becoming more difficult to mentor with many hospital midwives not so keen to mentor. This needs to be part of their professional development if needs be

Rural and remote midwives

Rural and remote midwives either strongly agreed (68/168, 41%) or agreed with the NZCOM mentoring statement (84/168, 50%). Respondents were mostly likely to think mentoring could be achieved through formal pre-arranged meetings (n=127/168, 76%); informal meetings when the need arises (n=141/168, 84%), face-to-face contact in the clinical setting (n=142/168, 85%); face-to-face contact away from clinical setting (n=129/168, 77%); or by telephone (145/168, 86%) Table 5.

Table 5. How rural/remote mentoring could be achieved

How mentoring can be achieved	**n**	**%**
Formal, pre-arranged meetings	127	76
Informal meetings when the need arises	141	84
Face-to-face contact in clinical setting	142	85
Face-to-face contact away from clinical setting	129	77
Hui/marae based meetings	30	18
Telephone contact	145	86
Fax	27	16
Mail	19	11
Email	49	30
Video-conferencing	19	12
Internet chat	19	12

The most likely barriers to being a mentor were lack of time (n=125/168, 74%); geographical isolation (n=93/168, 55%); lack of training (n=88/168, 52%); financial constraints (n=74/168, 33%). The most likely barriers to being mentored were unavailability of mentor (n=106/168, 63%); geographical isolation (n=90/168, 54%) financial constraints (n=81/168, 39%).

The role of the mentor was mostly considered to provide professional support (n=165/168, 98%); provide a safe place for reflection on practice (n=158/168, 94%); provide hands-on clinical support (n=136/168, 80%); provide hands-on clinical teaching (n=102/168, 61%); negotiate clear roles and responsibilities for both midwives (n=98/168, 58%); provide personal support (n=92/168, 55%). The responsibilities of the mentored midwife were felt by rural and remote midwives to remain accountable for her practice (n=165/168, 98%); be committed to the mentoring relationship (163/168, 97%); identify the issues she wants to address (150/168, 89%); expect to be challenged on her practice (149/168, 89%); actively listen to the mentor's advice and discuss reservations (149/168, 89%); identify her strengths and weaknesses (148/168, 88%) and honour the agreed relationship and role boundaries (147/168, 86%).

Rural and remote midwives mostly strongly agreed that mentors should be given financial incentives (n=49/168, 29%) or agreed (n=44/168, 26%). Participants mostly strongly agreed that becoming a mentor is a professional responsibility (n=63/168, 38%) or agreed (n=66/168, 40%).

Maori midwives

Maori midwives either strongly agreed (16/33, 49%) or agreed with the NZCOM mentoring statement (15/33, 46%). Respondents were mostly likely to think mentoring could be achieved through formal pre-arranged meetings (n=22/33, 67%); informal meetings when the need arises (n=22/33, 67%), face-to-face contact in the clinical setting (n=24/33, 73%); face-to-face contact away from clinical setting (n=26/33, 79%); or by telephone (25/33, 76%) Table 6.

Table 6. How mentoring can be achieved for Maori midwives

How mentoring can be achieved	n	%
Formal, pre-arranged meetings	22	76
Informal meetings when the need arises	22	84
Face-to-face contact in clinical setting	24	85
Face-to-face contact away from clinical setting	26	77
Hui/marae based meetings	16	18
Telephone contact	25	86
Fax	4	16
Mail	3	11
Email	12	30
Video-conferencing	2	12
Internet chat	2	12

The most likely barriers to being a mentor were lack of time (n=22/33, 67%); financial constraints (n=17/33, 52%); geographical isolation (n=15/33, 44%); lack of training (n=15/33, 44%). The most likely barriers to being mentored were lack of mentors from the same culture (24/33, 73%) and unavailability of mentor (n=21/33, 64%).

The Maori participants felt that the role of the mentor was to provide a safe environment for the mentored midwife to reflect on practice (n=33/33, 100%); negotiate clear roles and responsibilities for both midwives (n=27/33, 82%); provide hands-on clinical support n=27/33, 82%); provide cultural support (n=23/33, 70%); provide hands-on clinical teaching (n=23/33, 70%) and career development (n=20/33, 61%). The responsibilities of the mentored midwife were to be committed to the mentoring relationship (32/33, 97%); negotiate clear roles and responsibilities for both midwives (n=31/33, 94%); identify the issues she wants to address (31/33, 94%); remain accountable for her own practice (n=31/33, 94%); honour the agreed relationship and role boundaries (n=30/33, 91%); actively listen to the mentor's advice and discuss any reservations (n=29/33, 88%); expect to be challenged to identify her strengths and weaknesses (n=28/33, 85%); expect to be assisted with identifying ongoing educational and practice needs (n=28/33, 85%); expect to be challenged on issues affecting her midwifery practice (n=27/33, 82%) and expect to be encouraged to become active in midwifery networks (n=25/33, 76%).

Maori midwives mostly strongly agreed that mentors should be given financial incentives (n=14/33, 42%) or agreed (n=9/33, 22%). Participants mostly strongly agreed that

becoming a mentor is a professional responsibility (n=17/33, 52%) or agreed (n=13/33, 39%).

Twenty-four Maori midwives had been a mentor (73%). Two (6%) participants had not been asked to be a mentor and three (9%) participants felt they had not been registered long enough to be a mentor. The average length of time they mentored each midwife was two to six months (n=5/33, 15%) and seven months to one year (n=10/33, 30%). When asked if they continued to be a mentor, four (12%) participants answered that they were longer mentors because of a change of job and three (9%) felt being a mentor was too much of a time commitment.

Of the Maori respondents, 25 (76%) had been mentored. Maori midwives chose their mentor because they had had a relationship with her as a student (n=16/33, 48%); she worked in the same area (14/33, 42%); had the same midwifery philosophy (n=14/33, 42%); respected her midwifery practice (13/33, 39%); felt safe with her (13/33, 39%); had the same culture (5/33, 15%). The average length of time the respondents were mentored was most commonly from two to six months (n=10/33, 30%), or seven months to one year (n=11/33, 33%). When asked why they were no longer mentored, five (15%) respondents answered that they were still in an informal relationship with their mentor and five (15%) had no particular reason.

Discussion

Mentoring in New Zealand

This survey appears to have been very timely. The response rate (n=684/1577, 44%) and the effort that respondents put into answering the questionnaire is evidence that there is a lot of interest in the mentoring issue amongst midwives in NZ. Mentoring is an accepted practice in NZ with 51% (n=350/684) participants identifying that they had been mentors and about half the respondents had been mentored (n=349/684, 51%).

Competence and confidence

One theme that became apparent from this survey was the need for clarity around the definition of mentoring and what it involves. Mentoring as discussed by the participants of this survey was primarily working with new graduates especially LMC midwives, to develop competent clinical practice and skills. Respondents felt that mentoring could be achieved by face-to-face contact in the clinical setting (n=580/684, 84%). They also believed the responsibilities of the mentor was to provide hands-on clinical support (n=554/684, 81%) as well as provide hands-on clinical teaching (n=457/684, 67%). This suggests that there are midwives who believe mentoring should have an element of preceptorship or supervision as was required by hospital access agreements and practiced in the 1990s.

> *If I am mentoring I want to see how the person practices*

Whilst respondents strongly agreed (n=265, 39%) or agreed (n=339, 50%) with the NZCOM (2000) consensus statement that the purpose of mentoring "is to enable and develop professional confidence", there were also calls to have the concept of competence included in the NZCOM definition of mentoring. The issue of competence was mainly discussed in relation to new graduates, with some respondents implying that new graduates were not competent to practice without someone to oversee them.

> *New graduate LMC's are very vulnerable - they don't know what they don't know.*

> *I would be very concerned if my sister/daughter/friend was cared for by a new grad with no mentor.*

In contrast, respondents who had been mentored talked about development of 'confidence' rather than 'competence'. When asked about ending their mentoring relationships, respondents (n=158/349, 45%) answered that they did so when they felt confident to practice. The mentored midwives made no reference to mentoring as a tool for developing competence.

Internationally, preceptorship and/or supervision has been criticised as models for midwifery support since midwives are autonomous, competent practitioners at the point of registration (Cronk, 1994; Jackson, 1994). NZCOM has taken the same view that mentoring, like midwifery practice itself, must reflect the principles of autonomous professional judgement and decision making in relation to how the relationship develops and confident practice is achieved rather than development of clinical skills and competence (Armitage & Burnard, 1991), and at no time has suggested that a mentor should be spending large amounts of time with the mentee attending births or 'checking' her competence. NZ midwives are required by legislation to provide evidence of ongoing competence as part of the MCNZ re-certification program (Midwifery Council of New Zealand, 2005) so mentors should not feel they are responsible for another midwife's competence . Midwives must recognise the competence of new graduates at the point they enter the Register, and work with them to develop strategies so that they can become more confident in their practice.

Guidelines for mentoring

Whilst midwives appear to be committed to the concept of mentoring, another theme to emerge was that further guidelines or information is required so that midwives fully understand what their roles and responsibilities are within the mentoring relationship. Along side with guidelines was a demand for professional support and leadership from NZCOM on this issue.

> *Lack of mentoring guidelines. Insufficient standards for outcomes. Hit and miss approach currently inadequate and confusing for all.*
>
> *Some precise guidelines on mentoring would help*

Guidelines about the roles and responsibilities of the mentor may include aspects that the participants felt were important such as the provision of professional support (n=662/684, 97%) a safe environment for the mentored midwife to reflect on her practice (n=626/684, 92%). The main responsibilities of the mentors were to be good communicators (649/684, 95%); be respectful to the mentored midwife (n=636/684, 93%); non-judgemental (599/684, 88%); an experienced midwife (n=586/684, 86%). Meanwhile, the responsibilities of the mentored midwife were to identify the issues she wanted to address (n=624/684, 91%); honour the agreed relationship and role boundaries (602/684, 88%); actively listen to mentor's advice and discuss any reservations (n=610/684, 89%); remain accountable for her own practice (655/684, 96%). The New Zealand College of Midwives consensus statement does in fact refer to many of these aspects within its guiding principles. The midwives while expressing the need for more explicit guidance also valued the ability to have mentors responsive to individual need.

The guidelines could therefore include practical direction around the structure of the mentoring relationship, including time limits. Some respondents felt that the mentoring relationship needs to have a more formal structure with clear boundaries

> *I don't think mentoring should be defined so vaguely-as a loose agreement between two people-there are not enough guidelines-there needs to be a national consensus on a mentoring framework-to protect both mentor and mentee*

Needless to say, a formal arrangement with fixed constraints would not suit all midwives.

> *It is hard to define as individuals are so different. Much of the above statement is correct but I don't believe all mentorship relationships can be placed in a box*

The average length of time a mentoring relationship lasted appeared to be from six to 12 months. Mentors reported that mentoring relationships lasted two to six months (n=133/350, 38%) and seven months to one year (n=93/350, 27%); midwives who had been mentored explained their relationships lasted two to six months (n=126/349, 36%), or seven months to one year (n=100/349, 29%).

The NZ midwifery profession led by NZCOM is currently debating what mentoring means in the NZ context in order to reach consensus so that there is consistency

throughout the country. Clearer guidelines should develop as a result of this process; taking into allowance that mentoring means different things to different midwives. However, there should be recognition that mentoring is not a tool for developing competence, and that the whole issue of competence is managed by the NZMC. The discussion should consider what professional support midwives require, mentoring or preceptorship or both? Whatever model is developed, it must suit the NZ context and able to be applied to individual midwives' needs.

Mentoring for life

There was little mention by participants of mentoring being a tool for anyone other than new graduates. The main reason participants cited for being mentored was because they were new graduate LMCs (n=185/349, 53%). Only a very small number of respondents identified mentoring as a lifetime requirement (n=8/349, 2%) in an open-ended question about ending the mentoring relationship. There was no discussion of mentoring as a tool for lifelong learning or as a strategy to deal with professional issues such as recruitment and retention of experienced midwives. Some participants agreed that part of a mentor's role was to provide help with career development (n=364/684, 53%) but a larger number of participants felt the mentor's role was to provide clinical support and teaching, as previously discussed. On a national level, NZCOM will lead further discussion and exploration in order for midwives to appreciate the full benefits of mentoring, and understand that mentoring is a means for addressing professional issues other than support for new graduates.

Finance

The financial costs of mentoring were an issue for participants. The majority of respondents strongly agreed (n=238/684, 35%) or agreed (n=193/684, 28%) that mentors should be paid a financial incentive. Financial constraints were considered to be barriers both to being a mentor (n=316/684, 46%) and being mentored (n=312/684, 46%). A number of mentors reduced their workload/caseload when mentoring a midwife (n=80/350, 23%), which had a financial implication for the mentor. Whilst one does not want to encourage the idea that mentoring should have a financial arrangement, one has to ask what incentive there is for midwives to take on the role of mentor especially when

it can be so time-consuming. On the other hand, how reasonable is it to expect midwives, especially new graduates to pay for mentorship when they are just building up their business and trying to pay off large student loans? A number of respondents agreed that someone other than the mentee should pay mentors.

> *I strongly believe that mentoring should be part of the state training and funded by central government (Health Funding Authority or Ministry of Education) not by the mentored midwife - huge financial hardship for new self employed midwife*

Certainly the participants of this survey will be pleased to see that NZCOM has identified this issue as one that needs to be addressed with the Ministry of Health (MOH) (Guilliland, 2005)

Mentoring for core midwives

Whilst the majority of respondents were LMCs, a number of core midwives (24%, n=164/684) and managers (4%, n=26/684) completed the questionnaire. A small number of core midwives identified that a lack of institutional support is a barrier to being a mentor.

> *It is not something that core midwifery encourages. When/where and who pays would be an issue*

> *No plans to provide programmes in the workplace*

> *Lack of financial reparation and acknowledgement of the professional role as a mentor. Always an expectation as an employee that will 'do'*

The same lack of institutional support is a barrier to being mentored.

> *As core midwife, mentoring is not organised with us for this to happen*

All the same, core midwives were mentors (n=77/350, 22%) and were mentored (82/349, 24%). Mentoring schemes were provided for 24% (n=83/349) of the participants by their employers. Whilst core midwives face slightly different challenges to their LMC colleagues, mentoring should be equally as beneficial for them. Core midwives should not ignore the fact that they can play an important part in supporting their LMC colleagues, especially at times when LMCs need on the spot clinical advice or assistance. Nationally, core midwives ought to be involved in the discussion of how mentoring can

work for employed midwives, and work with NZCOM to develop guidelines that can be presented to their colleagues and employers.

Maori midwives and mentoring

A higher percentage of Maori midwives had been a mentor (n=24/33, 73%) compared to the general survey population (n=350/684, 51%), and had been mentored (n=25/33, 76%) compared to the survey population (n=349/684, 51%). This may be because as a minority group, Maori midwives are more cognisant of the need for supporting each other. The role of the mentor was thought to include providing cultural support (n=23/33, 82%) and mentoring could be provided in a hui/maree-based setting (n=16/33, 49%). However, the greatest barrier to being mentored was a lack of mentors from the same culture (24/33, 73%). The results of this survey cannot be generalised to the whole Maori midwifery population because of the small number of survey participants. Also, it would be inappropriate for the Pakeha author of this report to make recommendations regarding Maori midwives; nevertheless, the results of this survey suggest that Maori midwives have specific cultural considerations that should be supported. In particular, Maori midwives ought to have the opportunity to be mentored by a mentor of their own culture, which has been to be found to be more beneficial than being mentored by a mentor of a different culture (Buchanan, 1999; Smith et al., 2001). Nevertheless, this has implications for a group of midwives who are already stretched.

Student midwives

There was a link between working with a midwife when a student and then having her as a mentor, with 42% (n=147/349) participants saying they chose their mentor because they worked with her as a student. On the other hand, there was concern felt by several participants that new graduates who did not recognize a need for being mentored.

> *Being told they do not need a mentor as they are better trained than the 'older' experienced midwife trained prior to 1991 etc*

> *New grad often feel they are competent to go straight into independent practice which has been influenced by tech encouraging them to do so without adequate support*

It may be that education institutions can do more to facilitate mentoring for students before they complete their education program. Whilst mentoring is the responsibility of the new graduate to organise, it may be that education institutions can provide further education about what to look for in mentor and how to go about organising mentoring. This can be done in conjunction with NZCOM and employers.

Barriers to mentoring - time constraints

The main barrier to being a mentor was lack of time (n=554/684, 81%) and being mentored (n=297/684, 43%). However, if mentors can move their thinking about mentorship from spending huge amounts of time working in the clinical setting with the mentored midwife, that might help the problem of mentoring being so time consuming. This would also have a flow-on effect of being less of a financial commitment. As for hands-on guidance or support, a midwife can seek that from the midwives working along side her in her every day practice.

Availability

Unavailability of a mentor was the largest barrier to being mentored (n=439/684, 64%). It is probable that lack of financial remuneration, time constraints and lack of training (n=378/684, 55%) all add up to making mentors unavailable. Whilst a mentor may be available, she might not be suit the potential mentee. For a number of mentored midwives it was important that they were able to respect their mentor's practice (n=195/349, 56%); felt 'safe' with the mentor (176/349, 50%); and had the same midwifery philosophy (n=161/349, 46%). A strategy that may help midwives who are looking for a mentor is the development of a database of midwives who are available to be mentors. This could either be maintained centrally by the NZCOM national office or locally by each individual NZCOM region.

E-mentoring

A strategy to increase availability of mentors is to be creative with how mentoring is facilitated. Mentoring by electronic means may be effective for some midwives, especially as it can overcome geographical isolation. Rural/remote midwives in particular felt geographical isolation was a barrier to being a mentor (93/168, 55%) and being mentored (n=90/168, 54%). Already, the telephone is utilised by mentors (n=254/350,

73%) and mentored midwives (n=255/349, 73%). The Internet and e-mail may also play a part in mentoring. Fifteen mentored midwives (4%) and 28 mentors (8%) already use e-mail in their relationships. Whilst only a small number of midwives use the Internet and e-mail, participants in this survey acknowledged the potential of these avenues of communication. Participants felt that the telephone (n=546/684, 80%) and fax (n=102/684, 15%) could be utilised to achieve mentoring as well as e-mail (n=212/684, 31%), video-conferencing (n=75/684, 11%) and Internet 'chat' (n=82/684, 12%). Rural/remote midwives' level of interest in electronic communication such as e-mail (n=49/168, 30%), video-conferencing and 'chat' (n=19/168, 12%) was no higher than the general survey population. Considering their concerns about geographical isolation it could be postulated that they would be more aware of the possibilities of e-mentoring however the survey found that this was not the case. One reason may be that the rural environment does not necessarily lend itself to electronic communication because of the challenges of coverage and connection.

Survey participants felt that whatever form of communication worked should be employed.

> *Basically any form of communication as long as its sharing and open*

> *Each midwife is different some need more formal face-to-face contact, others don't. Need to decide together what will work best. Overall most important is being accessible*

Nevertheless, some participants had concerns about electronic communication.

> *I think mediums like fax, mail etc can be useful but mentoring requires a more immediate contact - I feel that personal contact is also required*

> *I think ideally mentoring shared by midwives geographically close so as to provide hands on support*

E-mentoring could be a viable option and requires further investigation especially for rural and Maori midwives, as it breaks down the barrier of location and increases the choice of mentor(Short, 2002; Waters, Clarke, Harris Ingall, & Dean-Jones, 2003).

Conclusion

Mentoring has been identified as a strategy that can strengthen the midwifery workforce in NZ. Whilst mentoring has been a concept that has been enacted since the early 1990s, there has been confusion about what it actually means to midwives, and inconsistency in how it operates in practice throughout the country. Midwives believe that mentoring can be important sources of support, especially for new graduates. They consider that NZCOM is the appropriate body to provide leadership in the development of guidelines about the roles and responsibilities of mentors and mentored midwives. These guidelines should make it clear that mentoring is not a tool for developing clinical competence but rather providing a strategy to grow confidence. Mentoring should not only be regarded as a source of support for new graduates but also as a means of professional development for all midwives including core midwives, whatever stage they are in their midwifery career.

The barriers to being a mentor are time constraints and financial obligations. Mentors are spending time attending births in the clinical setting with mentored midwives, which is time-consuming and means mentors have to reduce their own caseloads. However, if midwives received clinical support from the midwives they worked with in every day practice, the mentor can concentrate on providing opportunities for reflection and development away from the clinical environment, which can be managed in a way that is more conducive to the mentee's needs. The barriers to being a mentor reduce the number of mentors available to midwives who want to be mentored. Thus, it may be time to be creative and consider other ways of facilitating mentoring. Electronic communication may be one way of increasing availability of mentors, especially for midwives who are disadvantaged by geographical and cultural isolation. Midwives in NZ are committed to mentoring and look to NZCOM to lead the way in developing a framework that will make mentoring more achievable and available to all midwives.

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Appendix One

Mentoring and New Zealand Midwives: a survey of mentoring practice

What is this survey about?
This survey aims to find out more about what midwives think about mentoring. The survey explores your experience of mentoring and how would you like to see it work in New Zealand (NZ). By completing and returning this survey you will help us better understand what mentoring means to midwives.

More information about completing the survey
The survey should take between 15-20 minutes to complete.
The closing date for replies is 24th December 2004.
Completing the survey is voluntary and no one will be able to identify your answer. Please return it to me by folding the completed survey form as indicated and posting it. **Postage is free.**

Who is doing the research?
My name is Sarah Stewart and I am a NZ midwife and midwifery lecturer at Otago Polytechnic, Dunedin. I am also doing my PhD through the University of Queensland, Australia. I am working with the New Zealand College of Midwives (NZCOM) to complete this research. This survey has been cleared by one of the human ethics committees of the University of Queensland in accordance with Australia's National Health and Medical Research Council's guidelines.

What will happen with the research?
The research will be published in a report that I will give to NZCOM and be submitted for publication in professional journals. Only my supervisor and I will have access to the raw data, which will be kept securely at Otago Polytechnic for five years and then will be destroyed.

What will NZCOM do with the research report?
NZCOM will use the report to further develop systems of mentoring.

What if I want to know more?
You are free to discuss your participation with me or with NZCOM national office staff (03 377-2732). If you would like to speak to an officer of the University not involved in the survey, you may contact the Ethics Officer on +61 (7) 3365 3924. If you have any questions about this research, or if you would like me to post or e-mail you the research report, please let me know.

Please contact me:
Sarah Stewart
School of Midwifery, Otago Polytechnic
Forth St, Dunedin
E-mail: sarahs@tekotago.ac.nz
Phone: 03 4793642

My research supervisor is:
Professor Richard Wootton
University of Queensland
Brisbane 4072
E-mail: r_wootton@pobox.com
Phone: +61 (7) 3365 4671

Thank you for taking part in this research. We hope you enjoy completing the survey. Sarah Stewart and NZCOM

Section One - This section will ask for some personal information in order to make statistical classifications and comparisons.

1. What best describes your **main** job now? (Please only mark one category).

Hospital core midwife.....O
LMC midwife - employed .....O
LMC midwife - self-employed .....O
Research midwife.....O
Midwifery lecturer .....O
Midwifery manager.....O
Not practicing at the moment.....O
Other (Please specify)

_____
_____

2. What best describes your **main** practice setting? (Please only mark one category).

Urban midwife .....O
Rural midwife .....O
Remote .....O

3. What best describes your ethnicity? (Please only mark one category).

NZ European.....O
NZ Maori .....O
Samoan.....O
Cook Island Maori .....O
Tongan .....O
Niuean.....O
Other Pacific .....O
South East Asian.....O
Chinese.....O
Other .....O

4. How many years have you practised as a midwife?

Less than one year.....O
1 - 4 years.....O
5 - 9 years.....O
10 - 14 years.....O
15 - 19 years.....O
20 - 24 years.....O
25 - 29 years.....O
30 - 34 years.....O
35 years and over .....O

Section Two – This section will ask about your opinions of mentoring

5. *The mentoring relationship is one of negotiated partnership between two registered midwives. Its purpose is to enable and develop professional confidence. Its duration and structure is mutually defined and agreed by each partner* (NZCOM Consensus statement, 2000).

How do you feel about the statement?

Strongly agree .....O
Agree.....O
Undecided .....O
Disagree .....O
Strongly disagree .....O

6. If you disagreed with the above statement, how do you see mentoring?

_____
_____
_____
_____

7. How do you think mentoring can be achieved? (Please mark as many as you feel apply).

Formal, pre-arranged meetings .....O
Informal meetings when the need arises.....O
Face-to-face contact in clinical setting .....O
Face-to-face contact away from clinical setting .....O
Hui/marae based meetings .....O
Telephone contact .....O
Fax.....O
Mail .....O
E-mail.....O
Video-conferencing.....O
Internet 'chat'.....O
Other (Please specify)

_____
_____
_____

8. What do you think are the barriers to being a mentor? (Please mark as many as you feel apply).

Isolated geographical location .....O
Lack of support from colleagues.....O
Lack of time .....O
Financial constraints .....O
Lack of professional confidence .....O
Lack of personal confidence .....O
Emotional commitment .....O
Medico-legal risk .....O
Lack of mentoring training .....O
Fear of competition .....O
Other (Please specify)

_____
_____

9. What do you feel are the barriers to having a mentor? (Please mark as many as you feel apply).

Isolated geographical location .....O
Lack of support from colleagues.....O
Lack of time .....O
Financial constraints .....O
The perception that having a mentor is an admission of incompetence .....O
Fear of having practice criticised .....O
Unavailability of mentor .....O
Lack of midwives from same culture.....O
Other (Please specify)

_____
_____

10. What do you think is the role of the mentor? (Please mark as many as you feel apply).

Provide professional support.....O
Provide personal support.....O
Provide hands-on clinical support.....O
Provide hands-on clinical teaching.....O
Act as intermediary/advocate .....O
Negotiate clear roles and responsibilities for both midwives .....O
Provide safe environment for mentored midwife to reflect on practice.....O
Provide help with career development.....O
Provide cultural support.....O
Other (Please specify)

_____

11. What responsibilities do you think a mentor should have? (Please mark as many as you feel apply).

Be committed to the mentoring relationship.....O
Be readily available .....O
Be a good communicator .....O
Be a reflective questioner.....O
Non-judgemental.....O
Be respectful to the mentored midwife.....O
Be an experienced midwife.....O
Have a commitment to the development of midwifery practice.....O
Regularly reviewed by the Midwifery Standards Review Process .....O
Be actively involved in the midwifery profession .....O
Know the maternity service well .....O
Be a member of NZCOM .....O
Demonstrate an understanding of Tikanga Maori .....O
Have the ability to work in partnership with women.....O
Have undergone training to be a mentor.....O
Other (specify)

_____
_____

12. In your opinion, what are the responsibilities of the midwife who is being mentored? (Please mark as many as you feel apply).

Be committed to the mentoring relationship.....O
Negotiate clear roles and responsibilities for both midwives .....O
Identify the issues she wants to address.....O
Expect to be challenged on issues affecting her midwifery practice....O
Expect to be challenged to identify her strengths and weaknesses.....O
Honour the agreed relationship and role boundaries .....O
Actively listen to mentor's advice and discuss any reservations.....O
Remain accountable for her own practice.....O
Expect to be assisted with identifying ongoing educational and practice needs.....O
Expect to be encouraged to become active in midwifery networks.....O
Other (Please specify)

_____
_____

13. Mentors should be given financial incentives eg. paid by hospital employer or mentored midwife

Strongly agree .....O
Agree.....O
Undecided .....O
Disagree .....O
Strongly disagree .....O

14. Becoming a mentor at some time in my midwifery career is a professional responsibility.

Strongly agree .....O
Agree.....O
Undecided .....O
Disagree .....O
Strongly disagree .....O

Section Three – This section will ask about your experiences of being a mentor.

15. Have you ever been/are currently a mentor? Yes / No

If yes, pass onto Question 17

16. Are there any particular reasons why you have not been a mentor?

_____
_____
_____
_____

Go to Section Four, page 9

17. What made you decide to be a mentor?

Personal career development .....O
Develop interpersonal communication skills.....O
To share knowledge .....O
To work collaboratively.....O
To attract another midwife into my practice.....O
Required by my employer .....O
Other (Please specify)

_____
_____

18. Which best describes your job when you were a mentor?

Hospital core midwife.....O
LMC midwife – employed.....O
LMC midwife – self-employed.....O
Research midwife.....O
Midwifery lecturer .....O
Midwifery manager.....O
Not practising as midwife .....O
Other (Please specify)

_____
_____

19. What arrangements did you make around your own workload management and availability in order to be a mentor?

_____
_____
_____

20. How did communication with your mentored midwife take place? (Please mark as many as you feel apply).

Formal, pre-arranged meetings .....O
Informal meetings when the need arose.....O
Face-to-face contact in clinical setting .....O
Face-to-face contact away from clinical setting .....O
Hui/marae based meetings .....O
Telephone contact .....O
Fax
Mail .....O
E-mail.....O
Video-conferencing.....O
Internet 'chat' .....O
Other (Please specify)

_____
_____
_____

21. How often did you meet with the mentored midwife?

At least once a week .....O
2-3 times per week .....O
Once a month .....O
2-3 times per month .....O
2-3 times per year.....O
Other (Please specify)

_____
_____

22. How long have you been a mentor on average for each mentored midwife?

_____
_____
_____

23. What influenced your decision to no longer be a mentor?

_____
_____
_____
_____

Section Four – This section will ask about your experiences of being a midwife who has been mentored.

24. Have you ever been mentored? Yes / No

If yes, pass onto Question 26

25. Are there any particular reasons why you have not been mentored?

_____
_____
_____
_____

Go to end of survey

26. What made you decide to have a mentor?

New graduate working as LMC .....O
New graduate working as core midwife .....O
New to New Zealand midwifery practice .....O
Return to midwifery practice .....O
Change of role (eg. LMC to core; core to LMC) .....O
Change of location (eg. urban to rural) .....O
Moved into a non clinical role e.g. manager, education .....O
Working with women of a different culture from your own .....O
Other (Please specify)

_____
_____

27. Which best describes your job when you were mentored?

Hospital core midwife.....O
LMC midwife – employed.....O
LMC midwife - self-employed .....O
Research midwife.....O
Midwifery lecturer .....O
Midwifery manager.....O
Not practising as midwife .....O
Other (Please specify)

_____
_____

28. How did you choose your mentor? (Please mark as many as you feel apply).

I developed a relationship with her when I was a student .....O
She worked in the same group practice as I did.....O
She worked in the same area as I did e.g. hospital, community or education institution.....O
Mentoring scheme was provided by employer eg hospital.....O
I respected her midwifery practice.....O
She had the same midwifery philosophy as me .....O
She practised in the same way as I did .....O
She was a friend .....O
I felt 'safe' with her.....O
She was from the same cultural background as me .....O
Other (Please specify)

_____
_____

29. What arrangements did you make around your own workload management and availability in order to be mentored?

_____
_____
_____
_____

30. How did communication with your mentor take place? (Please mark as many as you feel apply).

Formal, pre-arranged meetings .....O
Informal meetings when the need arose.....O
Face-to-face contact in clinical setting .....O
Face-to-face contact away from clinical setting .....O
Hui/marae based meetings .....O
Telephone contact .....O
Fax.....O
E-mail.....O
Video-conferencing.....O
Internet 'chat' .....O
Other (Please specify)

_____
_____

31. How often did you meet with your mentor?

At least once a week .....O
2-3 times per week .....O
Once a month .....O
2-3 times per month .....O
2-3 times per year.....O

32. How long have you been mentored/were you mentored?

_____
_____

33. If applicable, why did you decide you no longer wanted to be mentored?

_____
_____
_____
_____

Thank you very much for completing this survey. Please fold as indicated and post. Postage is free.