



Student midwives' lived experiences of clinical practice during pre-registration education

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ABSTRACT

Aim: This study explored student midwives in their transition into clinical practice during their programme, aiming to identify key enablers and barriers influencing their development into confident and competent practitioners.

Background: While educational programmes focus on developing clinical competence, less attention has been given to the nuances of student midwives transition. These factors are increasingly recognised as central to student well-being, learning and workforce retention.

Design: A hermeneutic phenomenological approach was adopted within a mixed-methods design to capture both the depth and breadth of student experience.

Methods: Data were collected from student midwives at one UK university using an online survey, focus groups and semi-structured interviews. Methodological triangulation enabled exploration of shared patterns while preserving individual lived experience. Reflexive thematic analysis was used to interpret the data within a strong conceptual framework, allowing themes to emerge beyond surface-level descriptions.

Results: Findings revealed strong intrinsic motivation rooted in vocational commitment and care, yet frequently challenged by emotionally demanding placements, inconsistent supervision, fragmented support structures and performance-driven clinical culture. Where students experienced emotionally intelligent supervision, continuity and peer support, they reported enhanced confidence, psychological safety and professional identity development.

Conclusions: Supervision should be reframed as a relational and reflective practice rather than a procedural requirement. Greater investment in protected supervisory roles, including Professional Midwifery Advocates (PMAs) and Clinical Practice Facilitators (CPFs), is essential. Embedding structured emotional support and reflective opportunities within clinical placements may enhance learning, well-being and long-term retention in the midwifery workforce.

Introduction

Midwifery workforce shortages and retention challenges are a global issue, reflecting widespread pressures across healthcare systems; State of the World's Midwifery report (United Nations Population Fund (UNFPA), 2021; Boyce and Andrea Nove et al., 2026) estimates a global shortage of 900,000 midwives. Globally, shortages vary greatly between regions, being particularly acute in low-income countries and in Africa with high income countries, including Europe, having the lowest shortages (Boyce and Andrea Nove et al., 2026). Australian studies highlight

the need to attract and retain midwives and propose provision of high-quality midwifery education as part of the response to addressing the problem (Warton et al., 2025). In the UK, this is situated within a broader workforce crisis. The Royal College of Midwives (Warton et al., 2025) and The King's Fund (Royal College of Midwives RCM, 2023) report significant midwifery shortages and a troubling trend of early-career attrition. Many student midwives, driven by a strong sense of vocation and commitment to woman-centred care, begin their educational journey with optimism. However, they often face an emotionally and physically demanding reality in clinical practice,

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characterised by staff shortages, inconsistent supervision and emotionally intense environments (King's Fund, 2017; Hunter and Warren, 2014).

The shift from classroom to clinical setting often brings students face-to-face with a more complex and pressurised environment than anticipated. The emotional labour of midwifery, combined with institutional pressures and sometimes fragmented support, can lead to feelings of inadequacy and self-doubt (Chenery-Morris et al., 2024). This emotional and professional turbulence not only impacts students' immediate performance but may also affect their long-term career intentions.

Existing literature highlights the high attrition rates among newly qualified midwives and identifies the transition period as a critical point of vulnerability (Hunter et al., 2019; Fenwick et al., 2012). Yet there remains a gap in understanding how student midwives make sense of and respond to these challenges in real-time, particularly within the context of emotional well-being, supervision and identity formation.

The transition into clinical practice is widely acknowledged as one of the most challenging and formative phases of midwifery education. For student midwives, this shift is often marked by a complex interplay of excitement, uncertainty, emotional labour and professional growth. While the importance of clinical placements in developing technical competence is well established, less attention has been given to the emotional and relational dimensions of this transition. This study addresses this gap by exploring how student midwives experience the transition into the workplace and how these experiences shape their confidence, identity and resilience.

The focus of the study explores the lived experiences of student midwives as they transition into clinical practice during their pre-registration programme, with a focus on the enablers and barriers to confidence, resilience and professional identity development, centring the voices of students navigating this transition. Transition is understood not simply as a move from education to employment, but as a complex psychological, social and professional process which exists when student midwives move into clinical practice from the classroom. Drawing on Van Gennep's concept of liminality, (Clements et al., 2013) this period can be understood as a 'betwixt and between' state, where students are no longer fully learners yet not fully recognised as practitioners, often accompanied by uncertainty, vulnerability and identity disruption. The theoretical framework integrates Meleis's Transition Theory, (Van Gennep, 1960) Bandura's Self-Efficacy Theory, (Meleis, 2010) Van Gennep's concept of liminality and Symbolic Interactionism (Bandura, 1977) to illuminate how student midwives make meaning of their experiences. Meleis's Transition Theory positions transition as a dynamic, multidimensional process that involves shifts in roles, relationships, identities and expectations, rather than a single event. The theory highlights how the quality of support, role clarity and organisational culture can shape whether a transition is experienced as healthy, empowering and confidence-building, or as destabilising and marked by uncertainty and self-doubt.

This study therefore contributes to the existing literature by moving beyond descriptive accounts of transition to explore how student midwives construct meaning within this process. It offers new insight into the formation of expectations, the role of emotional containment in learning and the experience of liminality as students occupy the space of being 'almost a midwife.'

Methods

This methodology aimed to give voice to student midwives and uncover the complex emotional, relational and systemic influences that shape their experiences of entering the clinical workplace. It acknowledges that transition is not simply a procedural step but a deeply human process of identity formation and adaptation

A mixed-methods design was employed to explore student midwives' experiences of clinical practice during their midwifery programme. The qualitative component, which is the focus of this article, was informed

by an interpretive approach to understanding participants' accounts of practice (Blumer, 1969). Data were collected from student midwives at a single UK university over an eight-month period through an online survey (n = 43), three focus groups (n = 18) and in-depth semi-structured interviews (n = 16). Participants were recruited from across all three years of the programme, reflecting a range of ages, ethnicities and prior healthcare experience. This enabled exploration of how clinical practice is experienced at different stages of pre-registration midwifery education.

Ethical approval was granted by the university's Research Ethics Committee (ID: 25651). Informed consent was obtained from all participants, with assurances of anonymity and confidentiality. Given the researcher's dual role as Director of Programmes and Lead Midwife for Education, careful consideration was given to minimising potential power imbalances. Recruitment was facilitated via a gatekeeper and participation was sought following completion of summative assessments to reduce any perceived influence on academic progression. Participation was voluntary and all data were anonymised prior to analysis. Reflexive practices, including the use of a reflective journal and ongoing supervisory discussion, were employed to support critical awareness of the researcher's positionality.

Reflexive Thematic analysis, as described by Braun and Clarke, (Blumer, 1969) was used to code and identify patterns across the data. Particular attention was given to emotional tone, contradictions and shifts in perspective. Analysis was iterative and reflective, moving between data segments and theoretical concepts to ensure depth and rigour. Themes were developed collaboratively with my co-authors, with regular peer debriefing and audit trails maintained to enhance credibility.

The analysis was further enriched by drawing on theoretical lenses that offer insight into transition and identity. Concepts such as psychological safety, (Braun and Clarke, 2021) compassionate leadership (Blumer, 1969) and containment (West, 2021) provided a useful framework for interpreting the relational dynamics within student experiences.

Findings

Four interrelated themes emerged from the data, each illustrating a facet of student midwives' experiences as they transitioned into clinical practice. The findings reflect the complexity, emotion and intensity of navigating this professional threshold.

Bridging expectation and reality

A prominent theme across interviews and focus groups was the gap between students' expectations of midwifery and the realities of clinical practice. Many participants described entering their training with idealised and often simplified understandings of the midwifery role, shaped by classroom-based learning that emphasised physiological birth, continuity of care and woman-centred practice. These expectations were further influenced by media portrayals, which frequently present midwifery as emotionally rewarding and relational and by personal motivations grounded in care, advocacy and making a positive difference. However, these preconceptions did not fully account for the complexity of clinical environments, including high workloads, medicalised care, time pressures and the emotional labour associated with exposure to trauma and risk. As a result, students often felt unprepared for the physical and emotional demands of practice:

"I thought it would be more nurturing, but some days it felt like surviving, not learning." (Interview 7)

Students described feeling overwhelmed by the fast pace of clinical areas, the unpredictability of births and the pressure to perform competently under scrutiny. This contrasted sharply with simulation labs and academic preparation:

"We had simulations, but nothing prepares you for the noise, the urgency, the emotions in a real emergency." (Focus Group 2)

The intensity of the transition often triggered imposter syndrome and self-doubt:

"You want to do well, but sometimes you're so scared of making a mistake you freeze up." (Interview 11)

"You're just constantly trying to prove you're good enough to be there, even to yourself." (Interview 3)

For some, the abrupt shift from student to practitioner-in-training disrupted their confidence and sense of belonging:

"I felt like I'd gone from the safety of the classroom into chaos. It was like culture shock." (Interview 9)

Supervision, containment and camaraderie

The quality of supervision significantly shaped students' placement experiences. Participants described a range of supervisory encounters from deeply affirming relationships to situations where they felt ignored or invisible:

"She believed in me before I believed in myself. That made all the difference." (Interview 6)

"You'd get someone different every shift and some didn't even introduce themselves. You just felt invisible." (Focus Group 3)

The presence of a consistent, supportive mentor or Practice Supervisor provided a sense of emotional containment and enhanced learning. In this context, containment refers to the process by which a more experienced practitioner recognises, holds and helps make sense of students' emotional responses to clinical experiences, particularly those that are complex, distressing, or overwhelming. These relationships were described as a buffer against the intensity of the clinical environment, enabling students to process their experiences safely, maintain emotional equilibrium and remain engaged in learning:

"When I knew who I was working with, I could prepare mentally. It made me feel safer." (Interview 4)

In contrast, inconsistent supervision led to confusion and undermined students' confidence:

"Sometimes it felt like I was starting from scratch every shift, re-proving myself all over again." (Focus Group 1)

Peer support emerged as a vital and reliable source of containment. Students found camaraderie, humour and honesty in their interactions with peers:

"I don't think I would've survived first year without my cohort group chat. It was where we were honest." (Interview 13)

"It was the only place I felt like I could say, 'Today was awful,' and not be judged." (Interview 14)

These informal peer networks helped students debrief emotionally, share practical advice and validate one another's struggles:

"You feel less alone when someone else says, 'Yeah, I cried in the changing room too.'" (Focus Group 2)

Emotional labour and the limits of resilience

The emotional toll of placements was a consistent theme, particularly in relation to exposure to trauma, high-stakes situations and the emotional needs of women and families. Many students described being unprepared for the depth of emotional labour required:

"One minute you're trying to support a woman through stillbirth, the next you're being critiqued on your notes. It's emotionally exhausting." (Interview 5)

"I went home and cried so many nights. Not because I couldn't cope, but because I had nowhere to put it all." (Interview 12)

There was a widespread desire for more formalised emotional support. While reflective logs and academic assignments offered a space for intellectual reflection, students felt they lacked safe, supported spaces to process emotionally:

"We have reflection logs, but it's not the same as having someone really sit with you and talk through what happened." (Focus Group 1)

The absence of structured debriefing left some students emotionally saturated:

"You carry it all shift after shift. No one checks in. You just get told to toughen up." (Interview 2)

The concept of resilience was critiqued by many participants. While they recognised the need for inner strength, they also expressed frustration at how the term was used to dismiss *the need for support*:

"It's always 'be resilient,' but that just made me feel weak when I struggled. I needed support, not slogans." (Interview 10)

"I started to think I was the problem, because everyone else seemed to be coping. But we were all just pretending." (Focus Group 3)

This theme underscored the emotional complexity of clinical learning and the danger of framing resilience as a purely individual attribute.

Identity formation and the liminal space

Students frequently described their transition into practice as a process of "becoming," a shift from student to practitioner that was not linear or straightforward. This experience can be understood as a liminal phase, in-between state where individuals are no longer fully students, yet not fully recognised or confident as autonomous practitioners. Within this space of transition, usual markers of identity, competence and belonging are unsettled, leading to feelings of instability, ambiguity and self-doubt. Being 'almost a midwife' placed students in a position where expectations increased, yet confidence and authority had not fully developed, intensifying their sense of uncertainty:

"You're expected to act like a midwife, but you're not there yet. It's a weird identity crisis." (Interview 8)

Students were aware of the expectations placed on them by themselves, their mentors and the institution and often felt caught between roles:

"Some days I felt like a professional, other days like an imposter in uniform." (Interview 1)

Role modelling was identified as a key influence on identity formation. Observing skilled, compassionate midwives inspired and guided students:

"I watched how she spoke to women and thought, 'That's the kind of midwife I want to be.'" (Interview 2)

However, negative experiences, such as being criticised publicly or feeling ignored, threatened students' emerging sense of self:

"If you're constantly criticised or ignored, you start wondering if you're cut out for this." (Focus Group 2)

"No one said 'well done.' I just felt like a burden, like I was in the way." (Interview 15)

These moments contributed to identity fragmentation and self-

doubt, particularly when students felt they had no safe space to explore or repair these feelings.

Students also noted that their identity was shaped by how others treated them:

“When the team included me, I felt like a midwife. When they didn’t, I felt like a nuisance.” (Interview 6)

This relational construction of identity reflects the importance of belonging and affirmation in professional development.

Overall, these four themes demonstrate the deeply human dimensions of becoming a midwife. The transition into clinical practice is not merely a matter of acquiring competence, but of negotiating self-worth, safety and identity in emotionally charged and high-stakes environments. The findings point to the need for emotionally literate supervision, peer-supported reflection and systemic acknowledgment of the emotional labour embedded in midwifery training.

Discussion

The findings presented underscore the importance of emotionally intelligent supervision, psychological safety and structured opportunities for reflection and peer support during the transition from university into clinical practice. These elements were shown to be central not only to the development of technical competence but also to confidence, belonging and professional identity formation. By focusing students’ perspectives, this research offers insight into transition as a relational, emotionally situated process rather than a linear progression of skill acquisition. While previous literature has highlighted the challenges of transition and the concept of reality shock, this study extends current understanding by examining how expectations are formed and experienced and by conceptualising transition as a liminal, emotionally mediated process shaped through relational interactions and informal support systems.

Entering and engaging with clinical practice emerged as a pivotal experience that was often destabilising for students at all stages of the programme. Participants described this as a period marked by emotional turbulence, identity negotiation and heightened vulnerability. While technical competence was recognised as essential, the data consistently demonstrated that students’ ability to learn, adapt and remain engaged was profoundly shaped by the emotional and relational context where learning occurred. Emotional containment, reflective support and a sense of belonging were not peripheral but foundational to the development of a coherent and enduring midwife identity. Without these conditions, students described a sense of merely “surviving” placements rather than thriving within them, with learning narrowed to task completion and self-protection.

A key challenge identified was the expectation reality gap. Participants’ accounts strongly echoed the concept of “reality shock,” (Bion, 1962) particularly during the early weeks of placement. Many students entered midwifery education with idealised expectations shaped by media portrayals, public narratives of midwifery as purely relational and empowering, or classroom-based learning that could not fully convey the emotional, physical and organisational demands of practice. When confronted with the realities of understaffed environments, exposure to trauma, high responsibility and emotionally complex care, students reported anxiety, confusion and a pervasive sense of personal failure. This dissonance often undermined confidence and contributed to early questioning of professional fit. These findings align with previous studies (Parham, 2004; Sidebotham et al., 2015) demonstrating that poorly managed expectations can compound feelings of inadequacy and accelerate disillusionment with the profession, particularly in the absence of supportive supervision.

Supervision emerged as one of the most influential factors shaping students’ experiences of transition. Drawing on Bion’s (West, 2021) theory of containment, emotionally intelligent supervision enabled students to feel psychologically “held,” allowing anxiety to be

acknowledged, processed and transformed into learning. Students’ repeated use of terms such as “safe,” “heard,” and “looked after” highlights the extent to which supervision functioned as an emotional anchor during moments of uncertainty. This closely aligns with Winnicott’s (Winnicott, 1960) concept of the holding environment, where relational consistency and emotional safety create the conditions necessary for growth, exploration and identity consolidation.

In contrast, where supervision was inconsistent, task-focused, or absent, students described experiences of disorientation, self-doubt and emotional withdrawal. Learning in these contexts became secondary to emotional survival, with students focusing on avoiding mistakes, criticism, or exposure rather than engaging reflectively with practice. Such environments not only constrained learning but also carried longer-term consequences for confidence and professional identity. These findings suggest that supervision cannot be reduced to assessment or oversight; rather, it is a relational practice that shapes how students experience themselves as emerging professionals.

Symbolic Interactionism (Bandura, 1977) provides a valuable lens through which to understand these processes of identity formation. Students’ sense of self as “becoming midwives” was constructed in real time through everyday interactions with mentors, midwives and peers. Seemingly small moments, being invited to participate in handovers, asked for an opinion, or praised for compassionate care, were experienced as deeply affirming and pivotal to confidence-building. Conversely, dismissive behaviour, lack of acknowledgement, or repeated exclusion from learning opportunities communicated powerful symbolic messages about students’ worth and legitimacy. Feedback, whether explicit or implicit, was internalised and became part of students’ evolving professional narratives. Negative encounters, particularly those involving criticism without explanation or being ignored during emotionally charged situations, had enduring effects on students’ sense of professional value.

Bandura’s Self-Efficacy Theory (Meleis, 2010) further illuminates how confidence developed, or eroded, during transition. Participants’ accounts demonstrated that self-efficacy was not an innate trait, but a relationally fostered process shaped by opportunities for mastery, vicarious learning through role models and affirming feedback. Students who felt believed in, were more willing to engage with complexity, take appropriate risks and persist through challenges. This finding is consistent with existing literature linking self-efficacy to clinical performance, academic success and retention in healthcare education (Kool et al., 2023; Rogers, 2016). Importantly, where students lacked affirmation or were exposed to repeated negative interactions, confidence diminished, reinforcing withdrawal and self-doubt.

Psychological safety, as conceptualised by Edmondson (Braun and Clarke, 2021) was foundational to students’ capacity to learn. In psychologically safe environments, students felt able to ask questions, admit uncertainty and learn from mistakes without fear of humiliation or retribution. These conditions were most often created by mentors who modelled compassion, humility and openness. West’s (Edmondson, 2018) model of compassionate leadership offers a useful framework for understanding how such behaviours foster inclusive learning environments. Students described compassionate leaders as “approachable,” “human,” and “role models,” in contrast to supervisors who appeared rushed, emotionally unavailable, or solely focused on performance metrics. The presence or absence of psychological safety directly shaped students’ willingness to engage, reflect and develop professionally.

Peer support, although informal and largely unrecognised in formal curricula, played a profound role in sustaining students through transition. WhatsApp groups, changing room conversations and peer mentoring functioned as surrogate support systems, offering emotional containment, validation and shared meaning-making. These findings reflect the concept of the hidden curriculum (NHS England, 2017), where unofficial social structures provide essential emotional education that formal systems often fail to deliver. The shared experience of transition fostered bonds that enabled honesty and reassurance,

particularly when institutional support felt inaccessible or insufficient.

A recurring tension in the data was the pervasive use of “resilience” as an individualised expectation rather than a collectively supported process. Students frequently described being told to “be resilient” without being offered the resources, time, or guidance necessary to develop resilience in practice. This framing positioned distress as a personal weakness rather than a rational response to challenging environments. As a result, resilience became a proxy for enduring poor conditions or coping alone. These accounts echo wider critiques of resilience discourse in healthcare (NHS England, 2017), which argue that overemphasising individual toughness can obscure systemic responsibility and silence legitimate emotional responses.

The findings suggest that resilience should instead be understood as a dynamic, relational process cultivated through support, reflection and validation. Educational programmes must therefore embed systemic strategies that enable resilience development, including facilitated debriefs following emotionally challenging experiences, narrative-based reflection, peer support initiatives and greater access to Practice Supervisors and PMAs trained in emotionally intelligent supervision. Such approaches recognise that resilience is not about suppressing emotion, but about being supported to process, learn and recover.

Several implications for education and clinical practice arise from this analysis. Clinical educators and mentors require preparation in compassionate supervision that acknowledges the emotional landscape of transition and their role in scaffolding professional identity. Institutions must protect time and resources for student support, as supervision is undermined when those providing it are themselves overstretched or unsupported. Regular access to psychologically safe reflective spaces should be embedded within placement structures, normalising emotional processing as a legitimate component of learning. A broader cultural shift is also needed to validate vulnerability as part of professional development, countering narratives of shame and isolation.

These findings further indicate a need for curriculum reform. Greater emphasis on emotional preparedness, reflective practice, emotional labour and workplace culture should be introduced early in training. While competency frameworks remain important, an overemphasis on documentation and task completion risks neglecting the relational and emotional dimensions that students identify as critical to their development. Models such as A-EQUIP, (Rogers, 2016) currently applied to qualified staff, offer potential for adaptation to student contexts through restorative and reflective supervision.

Institutional messaging also emerged as significant. Students interpreted cues about their worth and expectations not only from individuals but from systems, how rotas were allocated, how feedback was delivered and whether concerns were acknowledged. Consistent messaging that affirms students’ value and developmental trajectory contributed to a sense of belonging and direction, whereas silence or inaction reinforced feelings of marginalisation.

Finally, digital learning environments (O’Connor, 2025) offered both challenges and opportunities. Some students described online peer spaces as refuges during isolating placements. There is scope for educational institutions to build on this by facilitating moderated online forums or peer-led reflection groups that complement face-to-face support. Given the competing demands faced by students, flexible and accessible support mechanisms are increasingly important.

This study adds to the growing body of midwifery education literature by providing conceptual clarity around the relational and emotional dimensions of transition. In foregrounding liminality, emotional containment and expectation formation, it offers a more integrated understanding of how professional identity develops in complex clinical environments, moving beyond competence-based models towards a more holistic view of professional becoming.

Overall, this study advances understanding of transition in midwifery by moving beyond competence-based models to foreground emotionality, identity and system responsiveness. It reinforces the need

to view student midwives as whole persons navigating a formative and often fragile period and to design educational and clinical environments that support not just safe practice, but sustainable professional becoming.

Limitations

The study was conducted in a single UK university, which may limit transferability to other educational and clinical contexts. Participants self-selected to take part, potentially overrepresenting those with particularly strong transition experiences. As the data capture experiences during training rather than post-qualification outcomes, further longitudinal research is needed to explore the longer-term impact of transition on confidence, well-being and retention in the profession.

Conclusion

This study explored the lived experiences of student midwives as they transitioned into clinical practice and identified key factors shaping confidence, resilience and professional identity development. The findings demonstrate that transition is not solely a technical or educational process, but a deeply emotional and relational experience. Student midwives encountered significant challenges during this period, including reality shock, emotionally demanding placements, inconsistent supervision and variable access to support. These experiences directly influenced how students perceived themselves, their competence and their place in the profession.

The study found that emotionally intelligent supervision, psychological safety and opportunities for reflection and peer support were central to positive transition experiences. When students felt supported, listened to and valued, they reported increased confidence, stronger professional identity and greater engagement with learning. Conversely, environments characterised by poor supervision, limited feedback and emotional neglect contributed to self-doubt, withdrawal and distress, with clear implications for well-being and future retention.

These findings matter because the transition period represents a critical point at which student midwives either begin to consolidate a sustainable professional identity or experience early disillusionment. The quality of support during training placements has implications not only for individual students but also for workforce stability and retention. Addressing attrition in midwifery therefore requires attention to the emotional and relational conditions where students learn, not simply increased recruitment.

Meaningful change is required at educational, organisational and policy levels. Supervision should be reframed as a relational and reflective practice, adequately resourced and recognised as integral to learning. Structured opportunities for emotional reflection, debriefing and peer support should be embedded in clinical placements. Educational programmes should place greater emphasis on emotional preparedness, reflective practice and compassionate leadership. By prioritising psychologically safe learning environments, midwifery education can better support students through transition, strengthen professional identity and contribute to a more resilient and sustainable workforce.

CRedit authorship contribution statement

Liang Q. Liu: Supervision. **Jo Killingley:** Writing – original draft. **Betsy Thom:** Supervision.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests. Jo Killingley reports a relationship with Middlesex University that includes: employment and non-financial support. If there are other

authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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