

MIDWIFERY IN NEW SOUTH WALES: A CONTEMPORARY CASE STUDY

A thesis presented to the

Faculty of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree of

Master of Science in Community Health

by

KRISTINE ROBINSON

1994

©



National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file *Votre référence*

Our file *Notre référence*

THE AUTHOR HAS GRANTED AN IRREVOCABLE NON-EXCLUSIVE LICENCE ALLOWING THE NATIONAL LIBRARY OF CANADA TO REPRODUCE, LOAN, DISTRIBUTE OR SELL COPIES OF HIS/HER THESIS BY ANY MEANS AND IN ANY FORM OR FORMAT, MAKING THIS THESIS AVAILABLE TO INTERESTED PERSONS.

L'AUTEUR A ACCORDE UNE LICENCE IRREVOCABLE ET NON EXCLUSIVE PERMETTANT A LA BIBLIOTHEQUE NATIONALE DU CANADA DE REPRODUIRE, PRETER, DISTRIBUER OU VENDRE DES COPIES DE SA THESE DE QUELQUE MANIERE ET SOUS QUELQUE FORME QUE CE SOIT POUR METTRE DES EXEMPLAIRES DE CETTE THESE A LA DISPOSITION DES PERSONNE INTERESSEES.

THE AUTHOR RETAINS OWNERSHIP OF THE COPYRIGHT IN HIS/HER THESIS. NEITHER THE THESIS NOR SUBSTANTIAL EXTRACTS FROM IT MAY BE PRINTED OR OTHERWISE REPRODUCED WITHOUT HIS/HER PERMISSION.

L'AUTEUR CONSERVE LA PROPRIETE DU DROIT D'AUTEUR QUI PROTEGE SA THESE. NI LA THESE NI DES EXTRAITS SUBSTANTIELS DE CELLE-CI NE DOIVENT ETRE IMPRIMES OU AUTREMENT REPRODUITS SANS SON AUTORISATION.

ISBN 0-315-98972-6

Name KRISTINE ROBINSON

Dissertation Abstracts International is arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation. Enter the corresponding four-digit code in the spaces provided.

HEALTH AND ENVIRONMENTAL STUDIES
SUBJECT TERM

0380 U.M.I.
SUBJECT CODE

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS

- Architecture 0729
- Art History 0377
- Cinema 0900
- Dance 0378
- Fine Arts 0357
- Information Science 0723
- Journalism 0391
- Library Science 0399
- Mass Communications 0708
- Music 0413
- Speech Communication 0459
- Theater 0465

EDUCATION

- General 0515
- Administration 0514
- Adult and Continuing 0516
- Agricultural 0517
- Art 0273
- Bilingual and Multicultural 0282
- Business 0688
- Community College 0275
- Curriculum and Instruction 0727
- Early Childhood 0518
- Elementary 0524
- Finance 0277
- Guidance and Counseling 0519
- Health 0680
- Higher 0745
- History of 0520
- Home Economics 0278
- Industrial 0521
- Language and Literature 0279
- Mathematics 0280
- Music 0522
- Philosophy of 0998
- Physical 0523

- Psychology 0525
- Reading 0535
- Religious 0527
- Sciences 0714
- Secondary 0533
- Social Sciences 0534
- Sociology of 0340
- Special 0529
- Teacher Training 0530
- Technology 0710
- Tests and Measurements 0288
- Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS

- Language
 - General 0679
 - Ancient 0289
 - Linguistics 0290
 - Modern 0291
- Literature
 - General 0401
 - Classical 0294
 - Comparative 0295
 - Medieval 0297
 - Modern 0298
 - African 0316
 - American 0591
 - Asian 0305
 - Canadian (English) 0352
 - Canadian (French) 0355
 - English 0593
 - Germanic 0311
 - Latin American 0312
 - Middle Eastern 0315
 - Romance 0313
 - Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY

- Philosophy 0422
- Religion
 - General 0318
 - Biblical Studies 0321
 - Clergy 0319
 - History of 0320
 - Philosophy of 0322
 - Theology 0469

SOCIAL SCIENCES

- American Studies 0323
- Anthropology
 - Archaeology 0324
 - Cultural 0326
 - Physical 0327
- Business Administration
 - General 0310
 - Accounting 0272
 - Banking 0770
 - Management 0454
 - Marketing 0338
- Canadian Studies 0385
- Economics
 - General 0501
 - Agricultural 0503
 - Commerce-Business 0505
 - Finance 0508
 - History 0509
 - Labor 0510
 - Theory 0511
- Folklore 0358
- Geography 0366
- Gerontology 0351
- History
 - General 0578

- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337
- History of Science 0585
- Law 0398
- Political Science
 - General 0615
 - International Law and Relations 0616
 - Public Administration 0617
- Recreation 0814
- Social Work 0452
- Sociology
 - General 0626
 - Criminology and Penology 0627
 - Demography 0938
 - Ethnic and Racial Studies 0631
 - Individual and Family Studies 0628
 - Industrial and Labor Relations 0629
 - Public and Social Welfare 0630
 - Social Structure and Development 0700
 - Theory and Methods 0344
- Transportation 0709
- Urban and Regional Planning 0999
- Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES

- Agriculture
 - General 0473
 - Agronomy 0285
 - Animal Culture and Nutrition 0475
 - Animal Pathology 0476
 - Food Science and Technology 0359
 - Forestry and Wildlife 0478
 - Plant Culture 0479
 - Plant Pathology 0480
 - Plant Physiology 0817
 - Range Management 0777
 - Wood Technology 0746
- Biology
 - General 0306
 - Anatomy 0287
 - Biostatistics 0308
 - Botany 0309
 - Cell 0379
 - Ecology 0329
 - Entomology 0353
 - Genetics 0369
 - Limnology 0793
 - Microbiology 0410
 - Molecular 0307
 - Neuroscience 0317
 - Oceanography 0416
 - Physiology 0433
 - Radiation 0821
 - Veterinary Science 0778
 - Zoology 0472
- Biophysics
 - General 0786
 - Medical 0760

- Geodesy 0370
- Geology 0372
- Geophysics 0373
- Hydrology 0388
- Mineralogy 0411
- Paleobotany 0345
- Paleoecology 0426
- Paleontology 0418
- Paleozoology 0985
- Palynology 0427
- Physical Geography 0368
- Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES

- Environmental Sciences 0768
- Health Sciences
 - General 0566
 - Audiology 0300
 - Chemotherapy 0992
 - Dentistry 0567
 - Education 0350
 - Hospital Management 0769
 - Human Development 0758
 - Immunology 0982
 - Medicine and Surgery 0564
 - Mental Health 0347
 - Nursing 0569
 - Nutrition 0570
 - Obstetrics and Gynecology 0380
 - Occupational Health and Therapy 0354
 - Ophthalmology 0381
 - Pathology 0571
 - Pharmacology 0419
 - Pharmacy 0572
 - Physical Therapy 0382
 - Public Health 0573
 - Radiology 0574
 - Recreation 0575

- Speech Pathology 0460
- Toxicology 0383
- Home Economics 0386

PHYSICAL SCIENCES

- Pure Sciences
 - Chemistry
 - General 0485
 - Agricultural 0749
 - Analytical 0486
 - Biochemistry 0487
 - Inorganic 0488
 - Nuclear 0738
 - Organic 0490
 - Pharmaceutical 0491
 - Physical 0494
 - Polymer 0495
 - Radiation 0754
 - Mathematics 0405
 - Physics
 - General 0605
 - Acoustics 0986
 - Astronomy and Astrophysics 0606
 - Atmospheric Science 0608
 - Atomic 0748
 - Electronics and Electricity 0607
 - Elementary Particles and High Energy 0798
 - Fluid and Plasma 0759
 - Molecular 0609
 - Nuclear 0610
 - Optics 0752
 - Radiation 0756
 - Solid State 0611
 - Statistics 0463
- Applied Sciences
 - Applied Mechanics 0346
 - Computer Science 0984

- Engineering
 - General 0537
 - Aerospace 0538
 - Agricultural 0539
 - Automotive 0540
 - Biomedical 0541
 - Chemical 0542
 - Civil 0543
 - Electronics and Electrical 0544
 - Heat and Thermodynamics 0348
 - Hydraulic 0545
 - Industrial 0546
 - Marine 0547
 - Materials Science 0794
 - Mechanical 0548
 - Metallurgy 0743
 - Mining 0551
 - Nuclear 0552
 - Packaging 0549
 - Petroleum 0765
 - Sanitary and Municipal 0554
 - System Science 0790
 - Geotechnical 0428
 - Operations Research 0796
 - Plastics Technology 0795
 - Textile Technology 0994

PSYCHOLOGY

- General 0621
- Behavioral 0384
- Clinical 0622
- Developmental 0620
- Experimental 0623
- Industrial 0624
- Personality 0625
- Physiological 0989
- Psychobiology 0349
- Psychometrics 0632
- Social 0451

- EARTH SCIENCES**
- Biogeochemistry 0425
- Geochemistry 0996



MIDWIFERY IN NEW SOUTH WALES:

A CONTEMPORARY CASE STUDY

BY

KRISTINE ROBINSON

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

© 1994

Permission has been granted to the LIBRARY OF THE UNIVERSITY OF MANITOBA to lend or sell copies of this thesis, to the NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film, and UNIVERSITY MICROFILMS to publish an abstract of this thesis.

The author reserves other publications rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's permission.

Dedicated to the memory of my father

ABSTRACT

The role of the midwife throughout the world is in a state of change. This is particularly true of midwifery in the Western world as the profession strives to maintain, or in some cases re-establish a primary role in the care of childbearing women. In this study, the current state of midwifery in New South Wales is examined, utilizing a case-study methodology. The regulatory structure, education and practice of midwives are described in detail. Issues related to the autonomy of the profession are also explored through in-depth interviews with midwives.

The results of the study indicate that midwifery in New South Wales is in a dynamic state as changes are occurring in the regulatory structure of the profession, the education and practice of midwives. The autonomy of the profession is subject to the influence of a number of complex factors including the relationship of midwives with medicine and nursing, issues within the profession itself, the setting of practice and finally, midwives' relationship with women.

The findings of the study and their relevance to the development of midwifery in Canada are also presented.

ACKNOWLEDGEMENTS

I would like to thank the Manitoba Health Research Council for providing me with financial assistance for this research and for acknowledging that the study of midwifery is a subject worthy of financial support.

I deeply grateful to the Chair of my thesis committee, Dr. Patricia Kaufert, whose wisdom and guidance during this project were invaluable to me. I consider it a privilege to have had the opportunity to work with an individual whose academic standards are of the highest order. Thanks also to the other members of my committee, Dr. Cam Mustard and Professor Lesley Barclay (in Australia) for their comments and suggestions regarding the thesis.

This project would never have been possible without the cooperation and assistance of the midwives of New South Wales. I would like to thank all of those midwives who took the time to share their thoughts about their profession with me. Their honesty and openness provided richness to this study. I am especially thankful to the Executive of the New South Wales Midwives Association and their President at the time, Pauline Green, for welcoming me as a colleague and providing me with such valuable assistance with my research. I owe a very special thank you to Pam Hayes who despite her very busy life, literally spent hours with me, answering my questions and sharing her thoughts about midwifery with me. Her knowledge of and commitment to midwifery was inspiring. Thanks also to Maureen Ryan who not only assisted me with my research, but was a great friend to my family and I during our time in Sydney.

I would also like to acknowledge the contribution to my career of Lesley Knight RN, SCM, my "midwifery mentor". Years ago in Gjoa Haven, NWT I watched her practise midwifery with wisdom, skill and love and those memories have never left me. It was that experience, early in my working life, that initiated my desire to become a midwife.

I am also very grateful to my mother and sisters, Maureen and Gay for always being interested in my work and for their constant encouragement throughout this project. To my dear children Conar and Kiera, thank you for always being there as a reminder of what is truly important in life. Finally, deepest thanks to John O'Neil, my partner in life, thanks for your love and for always knowing when to give just the right kind of support.

LIST OF FIGURES

FIGURE 1	Conceptual Model	14
FIGURE 2	Map of Australia	82
FIGURE 3	NSW Members of ACMI	116
FIGURE 4	Changes in Midwife's Place of Employment	117
FIGURE 5	Changes in Midwife's Type of Employment	118

TABLE OF CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
LIST OF FIGURES	iv
CHAPTER ONE	1
1.0 Introduction	1
1.1 Background	2
1.2 Research design and objectives	4
1.3 Thesis outline	5
CHAPTER TWO	6
2.0 Conceptual framework and literature review	6
2.1 Sociological perspectives on health professions	6
2.2 Professional autonomy: a conceptual model	11
2.3 Literature review	15
2.4 Summary	29
CHAPTER THREE	32
3.0 Research methodology	32

3.1	Study site	33
3.2	Research design	34
3.3	Access issues	34
3.4	Data collection	35
3.4.1	Documents/archival records	35
3.4.2	Site visits	36
3.4.3	Observational settings	37
3.5	Selection of key informants	37
3.5.1	The interview process	38
3.5.2	Interview format	38
3.6	Data analysis	40
3.6.1	Documents/archival records	40
3.6.2	Field notes	40
3.6.3	Key informant interviews	41
3.7	Ethical considerations	42
3.8	Limitations and sources of bias	42
CHAPTER FOUR		45
4.0	The Australian health care system: an overview	45
4.1	Background	45
4.2	Power and responsibilities in health care	47
4.2.1	The role of government	47

		viii
	4.2.1.1	Health care funding 47
	4.2.1.2	The provision of health care services 48
	4.2.1.3	Regulation of health services and health care providers 49
4.3		The role of the private sector 49
4.4		Health care costs 50
	4.4.1	Pattern of expenditures 51
	4.4.2	Health insurance: public 52
	4.4.3	Health insurance: private 55
4.5		Hospital services 56
4.6		The division of labour in health care 57
4.7		Population health status 59
4.8		The distribution of health care 61
4.9		Summary 63
CHAPTER FIVE		66
5.0		Midwifery in Australia: an historical overview 66
5.1		Childbirth: an Aboriginal perspective 66
5.2		The development of midwifery in Australia 68
	5.2.1	The convict era 69
	5.2.2	The pioneer era 70
	5.2.3	Regulation and incorporation 72

5.2.4 Post World War I influences 75

5.2.5 Post World War II influences 77

5.2.6 The 1980's - a time of change 78

5.3 Summary 80

CHAPTER SIX 82

6.0 NSW: an overview 82

6.1.1 Geography, population and climate 82

6.1.2 Economy, population health status 84

6.2 Funding and organization of health services 85

6.3 Organization of perinatal services 86

6.4 Care of women in remote/isolated areas 88

6.5 Care of Aboriginal women 88

6.6 Workforce 89

6.7 Facts about childbirth in NSW 89

6.7.1 Demographic information 90

6.7.2 Antenatal care 91

6.7.3 Delivery 91

6.7.4 Maternal medical conditions/obstetrical complications . . . 93

6.7.5 Birth outcomes 94

6.7.6 Postpartum Care 95

6.8 The ministerial task force on obstetric services in NSW 96

CHAPTER SEVEN	98
7.0 Midwifery in NSW: a contemporary view	98
7.1 The regulation of midwives	98
7.2 Professional organizations of midwives	104
7.2.1 The New South Wales Midwives Association (NSWMA)	104
7.2.2 The Australian Society of Independent Midwives (ASIM)	106
7.3 Midwifery education	108
7.3.1 Continuing education for midwives	113
7.4 Midwifery practice in NSW	116
7.5 Current models of midwifery practice	119
7.5.1 The hospital based model	119
7.5.2.1 Unit based practice	120
7.5.2.2 Midwives clinics	121
7.5.2.3 Early postnatal discharge programs	122
7.5.2.4 Birth centre practice	123
7.5.2.5 Team midwifery	126
7.6 The independent practice model	128
7.6.1 Other areas of independent practice	131
7.7 The Shearman report: implications for midwifery practice	131
7.7.1 Implementation of the Shearman report	135
7.8 Lay midwifery practice	136

7.9	Summary	138
CHAPTER EIGHT		140
8.0	Achieving autonomy: a midwifery perspective	140
8.1	Autonomy: different meanings	142
8.2	Major themes	144
8.2.1	Lost skills	144
8.2.2	Reskilling	148
8.2.3	Sharing the territory	153
8.2.4	Barriers from within	159
8.2.5	Being with women	162
8.3	Discussion	166
CHAPTER NINE		174
9.0	Summary and conclusions	174
9.1	Discussion	177
9.1.1	Inter-professional relationships	178
9.1.2	Models of practice	182
9.1.3	Midwifery skills and education	183
9.1.4	Intra-professional issues	184
9.1.5	Women and midwives	186

	xii
BIBLIOGRAPHY	189
APPENDICES	209
APPENDIX 1: Definition and Core Competencies of the Midwife	210
APPENDIX 2: Consent For Participation	218
APPENDIX 3: Interview Schedule	219
APPENDIX 4: Classification of Obstetric Hospitals In New South Wales	220
APPENDIX 5: Study Protocol	222
APPENDIX 6: Midwives Data Collection	224

CHAPTER ONE

1.0 Introduction

Midwives throughout the world have much to learn from each other, not only in the areas of practice, education and research but in the way in which the profession struggles to preserve and in some cases establish a role within complex and ever changing societies. Many of the issues that face midwives are universal and are not subject to being contained within national boundaries. This is particularly true of midwives in the Western world who face similar challenges of preserving their unique role to women in childbirth as well as maintaining a degree of professional autonomy in keeping with their recognized scope of practice. These midwives function within health care systems where physicians have established a dominant role in the care of women during pregnancy and birth and where the management of childbirth has become increasingly complex. These central issues remain relevant in 1993 whether they involve midwifery in Australia, where the profession is recognized and fully integrated into the health care system, or in Canada where midwifery is in the process of gaining legal recognition. Therefore this study of midwifery in New South Wales (NSW), Australia holds valuable insights that are applicable to the development of midwifery in Canada.

1.1 Background

At the present time, no national policy on midwifery exists in Canada. Progress towards legalizing the profession is centred at the provincial level with provinces at various stages in this process. Ontario was the first province to legalize midwifery in December of 1992 and is scheduled to begin the first midwifery education program in Canada in September of 1993. In 1991, the Quebec government authorized the practice of midwifery within the context of eight pilot projects. In September 1992, the Alberta government designated midwifery as a health care discipline and in May 1993 the government of British Columbia announced its intention to legalize midwifery and incorporate the services of midwives into the existing health care system. Finally, in Manitoba, two reports submitted to government support the legalization of midwifery in principle while differing on specific matters of education and regulation of the profession (College of Physicians and Surgeons and Manitoba Association of Registered Nurses Report 1991, MACSW Report 1988). The most recent report, that of the Working Group on Midwifery in Manitoba, was submitted to the Minister of Health in January 1993, but has yet to be released to the public.

Within Canada there are varying views on the mechanisms by which the profession of midwifery should be controlled and regulated and how midwives should be educated. Supporters of midwifery generally agree that midwives must work within the health care system and with other health care professionals. They also generally agree that the scope of practice should be sufficiently wide to allow for midwives to function in a variety of practice settings as well as rural, urban and isolated parts of Canada.

Agreement is lacking on the degree of professional autonomy midwives should have, the mechanisms by which midwives should be controlled and regulated, and the degree of control they can exercise over their own practice.

The Ontario Task Force on Midwifery undertook an extensive review of midwifery in the United Kingdom, Scandinavia and the United States and produced valuable information on the education, regulation and scope of practice of midwives (Task Force Report 1987). However, these countries have a different socio-demographic profile when compared to Canada.

Australia is a country which has similarities with Canada in terms of its history, population composition and distribution. Like Canada, Australia was settled by immigrants from Northern Europe, primarily from Great Britain, but the population today is comprised of a multi-ethnic mix plus the indigenous people. Australia also shares similarities with Canada in terms of a comparable standard of living for its population, but with significantly lower standards for its Aboriginal people. It has similar rates of perinatal mortality and life expectancy for the general population but again with higher rates of mortality and lower life expectancy evident among Aboriginal people. The history and development of the professions of medicine and nursing are also comparable between the two countries. Like Canada, differences in health service provision vary across state boundaries. Australia and Canada also share similarities in the extent to which technology is used in pregnancy and childbirth and in the general state of obstetrical knowledge (Maternal and Perinatal Care in NSW, 1988). Unlike Canada,

however, midwifery is legal in Australia and is integrated into the health care system.

It is for these reasons that this study of midwifery in Australia has relevance to the development of midwifery within a Canadian context. Where possible, the insights derived from this study of midwifery in NSW will be related to the development of midwifery in Canada.

1.2 Research design and objectives

The overall aim of this project was to conduct a study of midwifery in Australia. Recognizing the limitations of conducting such a study on a national basis, one state, NSW, was chosen as the study site for the research project.

The specific objectives of the study were as follows:

- 1) To undertake a study of midwifery in NSW by examining three aspects of the profession; regulatory structure, education and practice.
- 2) To examine issues related to the autonomy of midwives from the viewpoint of members of the profession.

A case study method was used to study the current state of midwifery in NSW. This method used a variety of data sources including historical records, related documents, interviews, site visits. In-depth interviews with midwives were used to examine issues related to the autonomy of midwives in NSW. The study was conducted from June to December 1991.

1.3 Thesis outline

This thesis will be organized into nine chapters. Following this introductory chapter, Chapter Two will provide a review of the literature and will outline the conceptual framework used for the study. Chapter Three will describe how the study was designed and carried out. Chapter Four will provide a general overview of the history and organization of the Australian health care system. It will include details regarding health care funding, issues related to the delivery of health care services, the development of health care policy and facts regarding the health status of the population. Major features of the Australian and Canadian health care systems will also be compared and contrasted. In Chapter Five, the history of midwifery in Australia will be described and the current issues facing the profession from a national perspective will be highlighted. Chapter Six will provide a description of the case study site, NSW. Midwifery in NSW will be described in depth in Chapter Seven. This chapter will include an historical and contemporary perspective on the education and regulation of midwives, a detailed description of midwifery practice in NSW, and will highlight the current challenges which face the profession. Issues related to professional autonomy, from the viewpoint of midwives in NSW, will be presented in Chapter Eight. This chapter will discuss the results of in-depth interviews with midwives in NSW concerning this issue. The concluding chapter of the thesis will provide a summary of the findings of the study and will relate them to the development of midwifery in Canada.

CHAPTER TWO

2.0 Conceptual framework and literature review

The erosion in the role of the midwife is a common theme in international studies of midwifery (Oakley and Houd 1990). While the specific features that characterize the changing role of the midwife will vary from country to country, many issues are common to all. This chapter will provide a review of the literature related to the changing role of the midwife and will draw from the literature issues relevant to autonomy of the midwife—a central theme of this thesis. A conceptual framework for the analysis of professional autonomy will also be presented, providing a model for the analysis of the data obtained in this study of midwifery in NSW.

2.1 Sociological perspectives on health professions

Several theoretical concepts are useful in the analysis of health occupations. They include professionalization, proletarianization, medicalization and medical dominance.

The concept of professionalization is used to refer to the process by which an occupation comes to attain particular attributes and becomes self regulating (Coburn 1988). The ultimate goal of professionalization is the attainment of professional status and autonomy. The defining characteristics or attributes of a profession may range from an emphasis on the possession of unique knowledge and an orientation to service to a more detailed list of criteria. According to Benoit (1991) most sociological definitions define a profession as having most or all the following:

1. A specialized body of knowledge.
2. A process of formal training to acquire this knowledge and skills.
3. A commitment to public service.
4. An ethical base for practice.
5. Power to accredit new members and exclude others without formal credentials.
6. Relative autonomy from administrators, clients and other occupational groups.
7. An association membership for the purpose of establishing control over their specialty.

The concept of professionalization has been used in the analysis of health occupations such as nursing. In an analysis of Canadian nursing, Coburn (1988) argues that the content and nature of nursing has changed from its early goals of altruism, service and dedication to the care of the sick to a contemporary emphasis on greater credentialing, higher education and the development of nursing theory and research. All such activities characterize the struggle of nursing to free itself from the control of both physicians and the bureaucratic institutions (hospitals) in which most are employed.

At the same time, Coburn (ibid) suggests that nursing is undergoing a process of proletarianization. Central to this process are the defining features of moving from self-employment to wage labour, the organization of wage labour into large bureaucratic institutions, and finally, the subdivision of and deskilling of formally skilled work through a process of fragmentation and separation of the mental and manual components of the work. Nursing, he suggests, has moved from self-employment to employment by

others, and is now subject to managerial control in large complex health care institutions. Finally, the work of nurses has also increasingly become fragmented and routinized. Nurses are reacting to this process by increasing alienation, militancy and unionization but at the same time, some within the profession are increasing efforts toward professionalization.

Those who have applied the concept of professionalization to the study of midwifery have suggested that midwifery has not achieved full professional status but rather is a semi-professional engaged in the process of professionalization (Benoit 1991, Rothman 1984, Willis 1989). This is largely due to midwives' inability to secure relative autonomy in their professional practice and in some jurisdictions, achieve self regulation. Others maintain that Western midwives in fact have lost professional status, and have become deprofessionalized. This is largely due to the medicalization of childbirth by physicians who dominate most aspects of childbirth, including the work of both midwives and obstetrical nurses (Benoit 1991). In drawing the analogy between midwives and other present day service workers Benoit (ibid) suggests that midwives no longer possess the kind of professional freedom their forerunners enjoyed in solo practice, but are instead clinging to an ever dwindling mandate in the care of childbearing women. Like nurses, the work of midwives has also become increasingly fragmented and routinized. In order for midwives to perform their work effectively, "they are becoming more and more dependant on complex reproductive technology, and are accountable more to medical professionals and bureaucratic institutions than to the women in their care" (ibid:22).

The concepts of medicalization and medical dominance are frequently applied to the analysis of health care occupations. Medicalization is used to refer to a process whereby many aspects of life have come to be defined in medical terms and are now defined as medical problems. As the domain of medicine has enlarged, a wider range of human experiences such as old age, anxiety, addiction, and childbirth have come to be defined and treated according to the medical model (Willis 1989). Conrad and Schneider (1990) suggest that the process of medicalization occurs on three levels; first, conceptually when medical vocabulary is used to define a problem. Secondly, at the institutional level where medical personnel (usually physicians) define and supervise treatment, and are the gate-keepers to systems for treatment. Third and finally, at an interactional level at which physicians treat patients' difficulties as medical problems. Many authors suggest that the transformation of childbirth from a normal life experience to a medical event, combined with the control of physicians over all aspects of maternity care and the complex hierarchical nature of modern maternity institutions, is evidence of the pervasive medicalization of the birth process particularly in the Western world (Oakley 1984, Romalis 1981, Rothman 1984). The knowledge of childbirth has become a specialized subject analogous to other pathological processes within the domain of medicine, and medicine now has the power to control both the parameters of normal pregnancy and the criteria for measuring successful childbirth. The consequences of this medicalization of birth have been profound for both childbearing women and midwives. The midwife has been displaced from her central role in the care of women in childbirth and women have been prevented from active participation in the most essentially female

function, human reproduction (Rich 1975, Oakley 1980). A further consequence for midwives is that the process of medicalizing birth has created a model in which the services provided by physicians have come to be expected and desired by women contributing to the further erosion in the role of the midwife.

Finally, the concept of medical dominance is closely tied to the process of medicalization and has been used to illustrate concepts such as subordination, autonomy and control as they relate to the division of labour in health care. Medical dominance as defined by Friedson (1970) refers primarily to the relationship of the medical profession to most other health care occupations in the division of labour. Medicine, he argued, has assumed a dominant position in the occupational hierarchy of health care in which other occupations are obliged to work under the supervision of physicians and take orders from them. He adds:

With its exclusive license to practice medicine, prescribe controlled drugs, admit patients to hospitals and perform other critical gate-keeping functions, the medical profession is portrayed as having a monopoly over the provision of health care services (ibid:35)

The central feature of medical dominance is the power or autonomy of the medical profession to control the content of their work (and by implication the work of others) which according to Friedson is the defining characteristic of what it means to be a profession. While many of the other attributes of a profession are important such as possessing a unique body of knowledge and theory, an ethical basis for practice and commitment to the public service, the key to becoming a profession is having control over one's work and placement in an organized division of labour. In the division of

labour in health care, it is medicine that has such professional autonomy and all health occupations including midwives are therefore subordinate "semi-professions".

Can the concept of professional autonomy be adequately explained as simply having control over one's work or is it a more complex concept involving control of both the content of work and other aspects of an occupation's structure. The concept of professional autonomy will be examined in more detail in the following section of this chapter and will be developed as a conceptual framework for this study of midwifery.

2.2 Professional autonomy: a conceptual model

Some have suggested that as a profession, medicine is declining in power and dominance, and is becoming de-professionalized (Coburn and Kaufert 1988). Others have argued that although in decline, medicine has maintained its dominant position in the overall division of labour in health care. Friedson's concept of medical dominance in the division of labour in health care still holds true despite increasing involvement of government in the funding and allocation of health care resources. Critics of Friedson's work such as Coburn (1988) have maintained that the concept of professional autonomy which is so central to his analysis of medical dominance, is unclear and poorly developed conceptually.

Coburn maintains that professional autonomy, or controlling one's work, is a complex concept involving two main aspects. The first, occupational control, involves first recognition as a distinct and separate profession which ultimately becomes self-regulating. The second feature of professional autonomy involves control over the labour

process or simply stated, having control over one's work. Control over the labour process also involves power and authority at two levels. The first involves control over the boundaries of the job or the breadth of decision making. The second level involves control within that sphere, whether or not that sphere is controlled by others. Professional autonomy then can be viewed as a more complex concept involving both occupational control and control over the labour process. Seen in this way an occupation could have control over its regulatory structure and yet the scope of practice and actual work of that group is subject to the control of others.

In an analysis of Canadian nursing, Coburn (1988) maintains that at one time the nursing organizations were controlled by physicians resulting in the subordination of nurses. These organizations later became autonomous when they became controlled entirely by nurses. Therefore, first through occupational recognition, and later by gaining the power over its regulatory structure, nursing achieved occupational autonomy. However, the actual work of nurses has been and still is controlled by physicians, and by health care administrators. While nurses may have control over how their work is carried out, the overall aims of nursing work remain under control of medicine. As Coburn concludes, this control by others has been resisted by nursing. "The gaining of occupational control and autonomy has now been supplemented by various strategies all aimed at greater independence by nurses and control over the day-to-day tasks both in the hospital and (they hope) outside in the community as primary care workers" (ibid: 453).

Professional autonomy can also be viewed as a dynamic concept with variable degrees of autonomy particularly at the level of the labour process. It is at this level that the influence of a number of variables will determine how much control an occupation will exercise over its work in any particular setting. These other influences include inter-professional relationships, forces within the profession, the process by which the knowledge and tools of the profession are acquired, the relationship of the profession to the consumers of its care and finally, the features of the work setting itself. Attempts by an occupation to increase its degree of autonomy will involve efforts and the resolution of issues at both the level of occupational autonomy and at the labour process level. This process will also entail efforts to mediate the effect of the additional influencing variables as described above.

The following diagram illustrates the key elements of Coburn's approach. It provides a conceptual model of professional autonomy which will form the basis for the analysis of the data obtained in this study of midwifery in NSW.

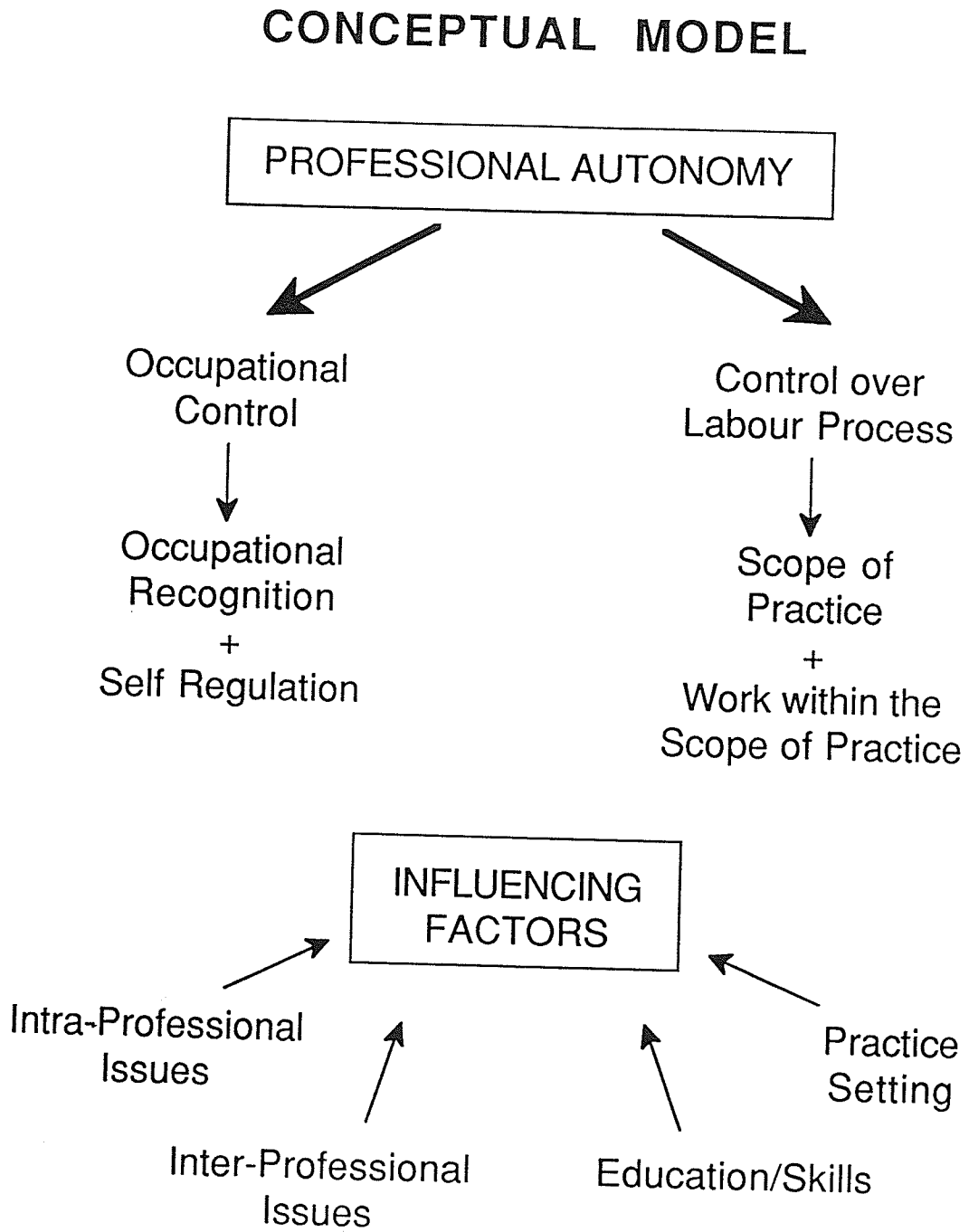


Figure 1

Conceptual Model

The remainder of this chapter will provide a review of the literature relevant to the changing role of the midwife and will focus on the variables which influence the autonomy of midwives both at the level of occupational control and at the labour process level.

2.3 Literature review

The concept of professional autonomy is implied in the widely accepted definition of the midwife (International Confederation of Midwives, International Federation of Gynaecologists and Obstetricians, World Health Organization, 1972).

A midwife is a person having been regularly admitted to a midwifery education program duly recognized in the country in which it is located has successfully completed the prescribed course of studies in midwifery and has acquired the qualifications to be registered and/or legally licensed to practise midwifery.

They must be able to give the necessary supervision, care and advice to women during pregnancy, labour and post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. They have an important task in health counselling and education, not only for their patients, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. They may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

This definition suggests that the midwives knowledge of pregnancy and birth enable her to care for women "on her own responsibility". The midwives claim to a scope of practice are legitimized by a possession of knowledge and expertise in the care of women during pregnancy. This knowledge of childbirth is based not only on an

understanding of the physiological basis of pregnancy, but on the specific knowledge and unique understanding of a particular woman and her pregnancy. The skills of the midwife are primarily of a non-technical "hands-on" nature and include skilled support of women to achieve birth without intervention. This knowledge and skill are integrated into a model of birth which emphasizes a holistic view of pregnancy and birth and where birth is seen as a normal life event not an illness or disease state (Lichtman 1988). This approach to childbirth also acknowledges the importance of emotional, psychological, and cultural influences on birth and is characterized by an emphasis on counselling and support.

In contrast, the medical model of birth tends to view birth more as an illness or a potentially abnormal activity (Oakley 1980). Physicians therefore, are primarily concerned with the application of scientific knowledge to assure the physical wellbeing of the mother and child with a resultant emphasis on physiological and abnormal aspects of pregnancy (Walker 1976).

The predominance of the medical model and the medicalization of birth has consequences both for the claim by midwives to a unique scope of practice and to the knowledge and skill which midwives bring to their practice. Some authors suggest that the power to define normalcy in childbirth has come to be determined by medicine (Annandale 1989, Rothman 1984). The resulting tendency to view birth as abnormal and only normal in retrospect has caused some midwives to observe "where all was normal until shown to be otherwise, the reverse now appears to be true" (Walker 1976). As a result, the midwife finds her opportunities to act "on her own responsibility" and function

in an autonomous role limited as the number of births classified as normal dwindles. This change in the fundamental manner in which the process of birth is conceptualized ie. potentially abnormal vs. normal has resulted in a change in how birth is managed and a divergence of skills between midwives and physicians.

Some authors have observed that the distinction between the management of normal and abnormal pregnancy has increasingly become blurred (Robinson 1989, Tew 1990). The care of women experiencing normal pregnancy now may include a number of routine diagnostic and preventative measures, some of which can only be performed by physicians. As new techniques to gain more information about pregnancy become routine, the involvement of physicians in normal pregnancy becomes essential since they control the means to obtain this necessary knowledge.

As the management of childbirth becomes more scientific and technological, the midwife is also forced to rely more heavily on increasingly complex technology in order to do her job. Some have suggested that in order to maintain a role, midwives have in fact been forced to re-skill themselves in new techniques which in many cases involve complex technology (Broome 1984, Lewthwaite and Robinson 1989). In some cases, mastering the technology has taken precedence over the use of non technical methods of assessment which are the traditional skills of midwifery (Garcia 1985). As these non-technical skills fall into disuse they erode, resulting in a loss of confidence in the midwives ability to use them. This "deskilling" of the midwife is also accelerated by the high value placed on technical and scientific skill at the expense of non-technical and traditional skills (Barclay 1985).

Several authors (Benoit 1991, McDonnell 1991, Robinson 1989, Willis 1989) have noted the significance that this deskilling of midwives has on the reproduction of knowledge. As the opportunities to use midwifery knowledge and skill diminish, practitioners lose confidence in their expertise and are less able to pass their knowledge on to new recruits to the profession. As experienced midwives become lost from the work force it becomes more and more difficult for students to learn from skilled experts. Thus the skill and knowledge which enable midwives to claim a right to autonomous practice are in danger of being lost.

The fundamental role that the educational process plays in the development of both the knowledge and skill of an occupation is highlighted by many authors. However, as McDonnell (1991) observes, many teachers of midwifery are no longer practitioners. Allowing the teachers of midwifery access to continued clinical practice has been suggested as one way of ensuring that they are able to remain clinically competent and are able to pass their skills to students (McDonnell 1991, Varney Burst 1990). In addition, McDonnell (ibid) suggests that in order to learn the skills that form the basis for independent decision making and autonomous practice, midwives must be allowed the flexibility to learn midwifery in a variety of settings other than the hospital. Most importantly, they must be allowed to learn midwifery in settings where the midwife is able to function independently. Some suggest that hospital based training for midwives not only diminishes a student's opportunity to gain expertise in normal midwifery, but the predominance of the medical model of childbirth also strengthens their orientation

towards viewing pregnancy as a disease and increases their dependence on technology (Benoit 1991, Robinson 1989).

In a study which compared three major styles of midwifery education-traditional apprenticeship, vocational schooling and university based-Benoit (1991) found that only in a vocational setting were students able to learn the art and science of midwifery and become competent committed practitioners. She describes the cottage hospital, the clinical setting for vocational schooling, as a "relatively autonomous space" where the midwife is able to create, transmit and apply her knowledge. Rothman (1990) concludes from a study of nurse midwives who changed their practice from hospital to home that changing the setting of practice required them to reinterpret much of their knowledge about childbirth which previously had been defined within a medical context. In many cases, they had to relearn the basic skills of midwifery which provided them a foundation from which independent care of childbearing women could be based.

Finally, a trend away from requiring education in nursing as a prerequisite for midwifery is occurring in the English speaking world, as midwives critically examine barriers to regaining professional autonomy. Many argue that nursing, with its history of subservience to medicine, does not prepare practitioners to function in a primary care role and therefore is inappropriate as the basis for midwifery education (D'Elmaine 1991, Ontario Report 1987, Willis 1989). As well, they maintain that prior training as a nurse only strengthens the view of pregnancy as an illness. An increasing tendency by midwives to see themselves as a separate occupation from nursing has resulted in some fundamental changes in the education of midwives in some jurisdictions. In the United Kingdom, the

number of direct entry programs has dramatically increased since 1985 as English midwives increasingly support the view that midwifery knowledge and skill are distinct and separate from nursing (Field 1990). In the United States, where the majority of practising midwives are nurse midwives, this trend may only be beginning. The American College of Nurse-Midwives has recently reaffirmed its position of preserving nursing as a prerequisite to midwifery (American College of Nurse-Midwives Position Statement, 1991) but is open to dialogue about the future feasibility of developing multiple routes of entry to midwifery education (Schlatter 1991).

The relationship between midwives and other health care professionals is another factor which must be considered when analyzing issues related to the autonomy of midwives. In the majority of jurisdictions where midwives have the legal right to practise, their control over the day to day work is subject to the influence of the medical profession. Both the boundaries of the midwives's job and the actual work of midwives are subject to this influence.

While the roles of the midwife and the obstetrician appear to be complementary with the midwife being responsible for the care of women experiencing normal pregnancy and the obstetrician with abnormality in pregnancy, the reality of midwifery practice is not consistent with this ideal division of labour. As Robinson (1989:165) observes:

The history of the midwife in Britain has been one of a gradual change in role from an independent practitioner providing comprehensive care throughout pregnancy and birth, to that of being a member of a team of health professionals in which the midwife is only to be involved in only one part of this care.

In a British study of the division of responsibility between midwives and other health professionals, Robinson (1983) examined the role of the midwife throughout pregnancy. In antenatal care, she found that although midwives were still involved in performing many of the tasks associated with antenatal care, the overall responsibility for antenatal assessment had been taken over by physicians. As well, she found that while the majority of deliveries in the UK were still conducted by midwives, their right to determine the pattern of care was diminishing as the involvement of physicians increased. In addition, she noted the introduction of policies for the management of labour further contributed to restricting the freedom of midwives to exercise their own judgement in the management of labour and delivery. These policies which set the boundaries for decision making by midwives, were generally formulated by medical staff. This process did not always include provision for prior consultation with senior midwives.

In a review of studies on the midwives's role in developed countries, Barclay (1985) also concluded that the midwives' autonomy was diminishing as a consequence of medical involvement in an increasing proportion of normal cases. A survey conducted by the WHO on perinatal services in the European region also found that the role of midwives was being diminished due to a number of factors which included the increasing involvement of obstetricians in the routine care of normal pregnancies, the replacement of midwives by nurses, and the movement of midwifery practice into hospital (WHO 1985).

Several authors (Walker 1976, Thompson 1990, Robinson 1989, Ryan 1991) have suggested that some confusion appears to exist between midwives and their medical

colleagues about the role and responsibilities of the midwife. Walker (1976) concluded from a study of midwives' and obstetricians' perceptions of the midwife's role that whereas midwives appeared to view their role as separate but complementary to that of the obstetrician, obstetricians saw midwives more as nurses who assisted them but who had more decision-making responsibility than a normal nurse. Obstetricians were more likely to see care in normal childbirth as an area where they had responsibility overall but which could be delegated to the midwife but also taken back at will. According to Walker (1976), in cases where conflict occurred between midwives and obstetricians, midwives were more likely to surrender their right to decision making and appeared to work harder at resolving conflict than their medical colleagues.

In a recent survey of midwives in Australia, the need for role clarification between midwives and obstetricians was identified (Ryan 1991). Improved understanding and respect for the contribution each makes to the care of childbearing women was suggested as a way to enhance the working relationship between the two professions. The author concludes from the results, that there is evidence of tension in the relationship between midwives and obstetricians, and this is most evident in larger maternity care units (ibid).

Graham (1991) in a U.S. study, examined the conflict that occurred between midwives and physicians when a nurse-midwifery program was added to a physician only service. In a structural analysis of physician-midwife interaction she describes the conflict that occurred as a result of each profession holding differing views on the role of the midwife, lines of authority and expected mechanisms for interprofessional collaboration. Her analysis suggested that midwives interpreted their role as separate

but equal to that of physicians. In contrast, physicians interpreted the relationship as hierarchical with physicians having ultimate authority over midwives. Graham suggests that in order for conflict and role ambiguity to be minimised, it is important for both groups to share the same view of their structural relationship, and to agree upon the extent and mechanism for collaboration. She concludes that where no formally recognized structure exists, the framework for interaction rests on patterns established in different settings. In some cases these patterns result in physicians exercising authority unilaterally in response to midwives increasing autonomy within their work setting (Breece 1989).

Finally, in a case study of obstetrics in the United States, Annandale (1989) concluded that the increasing popularity of midwives has contributed to the erosion of physician's monopoly of childbirth. From her study she concludes that the reaction of the medical profession has been to attempt to exercise greater control over the social organization of the workplace and the work of midwives. Their response to the increasing autonomy of midwives has been to impose more rigid definitions of normal birth and introduce strict protocols for the management of labour.

For some midwives the relationship with nurses compounds their struggle to achieve professional autonomy. Willis (1989) has suggested that the subordination of midwives in Australia was effectively achieved by their incorporation into nursing, an occupation which was structurally located in a position of subordination to medicine. Many suggest that nursing, because of its historical relationship of subservience to medicine has never been able to successfully claim a role as a primary care giver (Willis

1989, Sullivan and Weitz 1988). Being seen as a specialty of nursing then is problematic for midwives as they seek to reclaim their professional autonomy. As previously discussed in this chapter, many suggest that midwifery knowledge and skill are quite distinct and separate from nursing and so the basis of midwifery education in nursing is considered to be inappropriate. As well, some argue that in order to further their professional goals, midwives must also achieve occupational autonomy and secure the right to control the regulatory structure which governs the practice of midwives (Rothman 1984).

The degree of control that midwives have over their practice is also influenced by the setting in which they work. While the definition of the midwife acknowledges her right to practise in a variety of settings, in the United Kingdom, United States and Australia, the most common place of practice is the hospital. Robinson (1989) notes that the degree of independent decision making available to midwives will vary from country to country and from unit to unit within countries but of all the sites the hospital provides the most challenge to autonomous midwifery practice.

In Britain, several authors have noted that the decline in the autonomy of midwives has paralleled the move of birth from home to hospital (Kitzinger 1988, Oakley and Houd 1990, Robinson 1989, Tew 1990). While initially this involved more births taking place in smaller general practitioner units where the midwife continued to play a central role, Tew (1990) notes that a policy of centralization of maternity care predominated in the 1970's resulting in care being controlled in large units under the care of consultant obstetricians. Under such a system, continuity of care by a midwife was

difficult to accommodate, resulting in fragmentation in the role of the midwife and specialization in only one part of the care of women in childbirth.

As well, the concentration of maternity care in hospital further increased the medicalization of childbirth contributing to greater erosion of midwives autonomy (Field 1990, Robinson 1989, Tew 1990). In response to this Tew observes:

Midwives found practical compensation for the erosion of their independence and responsibility. To set against the loss of the job satisfaction of providing total continuous midwifery care is the attraction of predictable hours of work in hospital, albeit with the impaired satisfaction of providing fragmented care (ibid:15).

Only in the few remaining general practitioner units, separate from consultant units, where midwives able to retain a degree of autonomy (Robinson 1983, Green, Kitinger & Ceuphano 1986, Tew 1990). This is consistent with the findings from a study of midwives in Newfoundland and Labrador in which Benoit (1991) found that only in the small cottage hospitals were midwives able achieve professional autonomy, free from community and "medical-bureaucratic" control. In her study, she concluded that the size of the work site, the complexity of the division of labour and the level of technology proved critical in the degree to which midwives retained control over their work.

Several authors have noted that one of the reasons why the role of the midwife was diminished historically was due to a lack of organization on the part of the profession (Arney 1982, Barrington 1985, De Vries 1989, Donnison 1977, Willis 1989). In the case of Australia, the United States and Canada, this may have been due to the separation of midwives geographically but contemporary writers suggest a lack of unity

among present day midwives may be a contributing factor to disunity (DeVries 1989). This lack of solidarity has resulted in midwives being unable to protect their interests against domination by more powerful occupational groups such as medicine and nursing, therefore hampering a coordinated effort at achieving professional autonomy. Discord within the profession may be on the basis of fundamental issues such as education and the setting of practice.

In the United States the majority of midwives have prior education in nursing, and midwifery is generally seen as an advanced specialty of nursing. However, a comparatively smaller group of non-nurse, or lay midwives also practise in the United States. These midwives have received training in midwifery through a variety of means including apprenticeship with practising midwives, self-study and through non academic midwifery courses. Conflict between the two groups of midwives is evident as each proclaims to practise "real" midwifery (DeVries 1986). Lay midwives are critical of nurse-midwives because they feel nursing education strengthens the midwives' orientation to the medical model of childbirth and places them in a position of subordination to physicians (ibid, Sullivan and Weitz 1988). Nurse-midwives' criticisms of lay midwives include that they are uneducated, unsafe and contribute to the prevailing view of midwives as marginal healers (McCool 1989, Sullivan and Weitz 1988). Conflict among midwives may also arise from the setting of midwifery practice-some maintain that legitimate or real midwifery practice is only possible in the home setting and midwives who practise in an institutional setting are more like obstetrical nurses than midwives (Varney Burst 1989).

In some jurisdictions, this conflict has led to the creation of separate organizations of midwives each claiming to represent the legitimate interests of midwives. In Australia, midwives are represented both by the Australian College of Midwives Inc. (ACMI) as well the Australian Society of Independent Midwives (ASIM). Membership in ACMI is only open to registered midwives however, membership in ASIM is available both to registered midwives and the small group of lay midwives who practise in Australia. In Britain two organizations, the Royal College of Midwives and the Association of Radical Midwives represent midwives. Both groups represent registered midwives, but differences are apparent in the philosophy and objectives of each (Field 1990). In the United States, nurse-midwives are represented by the American College of Nurse-Midwives and lay midwives by the Midwifery Alliance of North America. Many authors (DeVries 1986, McDonnell 1991, Rothman 1984, Varney Burst 1989) maintain that this conflict within the profession itself is counterproductive, divisive and a major barrier to midwives achieving their professional goals.

Others suggest that midwives' strength lies in the ability of the profession to return to the basic purpose of midwifery and "be with women" (Barclay 1989, Oakley 1989). The recent success of midwives in Ontario and British Columbia in attaining the legal right to practise can in part be attributed to two groups of midwives, from nursing and non-nursing backgrounds, uniting toward a common goal of achieving occupational recognition (Ontario Report 1987, Relyea 1992). Flint (1989) suggests that midwives as a group must "heal from within" in order to protect their role and effectively care for women.

The importance of gender has been noted by many authors who have studied midwifery from both historical and contemporary perspectives (Arney 1982, Barclay 1985, Benoit 1991, De Vries 1986, Donnison 1977, Michaelson 1989, Rothman 1984, Willis 1989). Many suggest that while the process by which midwives have been dominated, particularly by "medical men" vary from country to country gender is a common factor. In short, it has been suggested that as a predominantly female occupation, midwifery has declined as a result of the overall domination of women by men in a patriarchal society. While many view gender as contributing to the demise of the midwife, others consider that the key to regaining autonomy is for midwives to once again align themselves with women who are increasingly looking for alternatives in childbirth (Newby 1990, Oakley 1989). Gender, has emerged as a important issue for midwives and serves as a basis for identification with the female client rather than the male physician. However, as several authors have noted, this process of realigning midwives with women must involve a re-education of all women about the role of the midwife and the value of midwifery care.

Some maintain that midwives, in their struggle to regain autonomy and professional status, have become aligned too closely with medicine (Barclay 1985, Pettingil 1990, Sullivan and Weitz 1988). Pettingil (1990) suggests that this is not unlike other subordinated groups who internalize the norms and values of the oppressor group because they feel it will lead to power. The result of this alignment with medicine, the dominant group, is that midwives have become alienated from women, the very group they claim to serve (Barclay 1985, Rothman 1984). Barclay (1985) suggests that

midwives' alignment with medicine has been a "strategic success" for medicine since it needs midwives to accept "vicarious prestige" from this relationship in order (for medicine) to maintain a position of dominance.

The emerging political power of women and visibility of women's health issues are considered to be trends that midwives must recognize and take action on (Newby 1991). Pettingil (1990) suggests that power for any occupational group will accrue through the development of a professional identity as individuals provide caring services. Power will be forthcoming from the users of the service as they perceive that their needs are being met and a demand for services is generated (ibid). Finally, recent evidence from an international perspective suggests that when midwives combine forces with women, changes in the provision of maternity care and an increase in the autonomy for midwives is both a realistic and achievable goal (House of Commons Report 1992, Relyea 1992).

2.4 Summary

This chapter has provided a review of the literature related to the changing role of midwives and presented a conceptual model that will be used in this study of midwifery in NSW.

A review of the literature suggests that the changing role and occupational autonomy of midwives has been influenced by a number of complex and inter-related processes. These include; the rise in dominance and influence of medicine over childbirth leading to the medicalization of the birth process and a change in the overall

management of childbirth. These historical processes facilitated a divergence of skill between midwives and medicine with greater value being placed on medical skill (the application of scientific principles) than those of midwives which are primarily of a non-technical nature. The change in the setting of birth, from home to hospital also accelerated the erosion in the role of the midwife in many jurisdictions. Although midwives and physicians continue to work with each other throughout the world, the relationship between the two is often characterized by conflict. Efforts by midwives to increase their occupational autonomy has often been met with resistance by organized medicine.

A re-emergence of a desire by women to have less intervention and decreased medical involvement in the birth process has stimulated greater public recognition of the midwives' role in enhancing normal birth. It has also prompted midwifery to re-examine its occupational identity, its commitment to women and its close relationship with other occupational groups, particularly nursing. Conflict among midwives is also evident as debates concerning the goals and issues facing midwifery emerge.

A model for conceptualizing professional autonomy was also presented in this chapter. Within this model, autonomy is viewed as a concept which includes both occupational control and control over the labour process or the actual work of any occupational group. Autonomy at both levels is subject to a variety of influences which include the process by which an occupation learns the skills it utilizes in practice, the setting of practice, inter and intra-professional issues, and the relationship of an

occupation with consumers of its care. The next chapter will outline the methods utilized in this study of midwifery in NSW.

CHAPTER THREE

3.0 Research methodology

The principle objectives of this project were to conduct a study of the profession of midwifery in New South Wales (NSW), Australia and to explore issues related to the autonomy of midwives in NSW from the viewpoint of members of the profession. These research objectives guided the process of selecting an appropriate research strategy. After reviewing the variety of research methods that were available, a case study approach was selected as the preferred strategy over survey or experimental methods due to the nature of the research question and in light of the unique features of a case study design.

As Yin (1989) suggests, case studies are the preferred strategies when "how" or "why" questions are being posed and when the investigator has little control over the events being studied. In addition, case study design is also an appropriate method to use when the study involves a contemporary phenomena in a real life context (ibid, Marshall and Rossman 1985). Yin (1989) also suggests that one strength of a case study strategy is that the data can come from a variety of sources including documents, archival records, interviews, direct observation, participant observation, and physical artifacts. These features of a case study design were particularly appropriate to meet the first research objective, that of describing the current status of midwifery in NSW. This objective required a descriptive approach, drawing on information collected from a variety of sources. In this way, the process of examining a broad range of historical,

attitudinal, and observational issues relevant to the current state of midwifery in NSW could be facilitated. This drawing together of variety of perspectives on a common point of interest is another strength of a case study approach (Marshall and Rossman 1989).

The second research objective which related to the autonomy of midwives in NSW, required a more focused approach. In addition to drawing on information about the autonomy of midwives from the above sources, key informant interviews were conducted. This drawing together of evidence from a variety of sources or triangulation (Yin 1989), formed the basis from which a further and more in-depth exploration of issues related to the autonomy from the viewpoint of midwives could be undertaken. In this way, the case study method facilitated the integration of both research objectives, and identified links between the history and current state of midwifery in NSW, and issues related to the autonomy of the profession.

3.1 Study site

NSW, the study site for this project is similar to Canada in many of the characteristics which make Australia a useful model in which to study midwifery. These include population composition and distribution, health status of the population, the general organization and funding of health services and finally, issues related to the provision of health care services to a variety of locations, including rural and remote areas. Unlike Canada however, NSW also has a long and rich history of midwifery

dating back to the arrival of the first settlers to Australia. A detailed description of NSW will be provided in chapter six of this thesis.

3.2 Research design

The study was designed in two parts. The first involved the collection of data which formed the basis of the case study and which described the infrastructure and foundation of midwifery in NSW. The primary sources of data were archival material, documents, interviews, site visits and non-participant observations at meetings. In the second part of the study, which focused on issues related to the autonomy of the midwife, interviews with selected key informants were the main data source.

The research was carried out in Sydney, NSW between July 1991 and December 1991.

3.3 Access issues

The initial period in the research process involved familiarizing myself with the history of midwifery in NSW as well as gaining an understanding of the current context of midwifery practice. It also involved developing an awareness of who the leaders of the profession were, and identifying those midwives who would become key informants in the study.

Initial contact was made with the Executive of the New South Wales Midwives Association (NSWMA). They were provided with a copy of the research proposal and a preliminary meeting was held with them to further explain the objectives of the

research and to answer any questions regarding the project. At the time of our initial meeting I also requested permission to attend the monthly meetings of the Executive of the Association in an observational capacity. A letter explaining the objectives of my research was included in the September issue of the Association newsletter.

3.4 Data collection

3.4.1 Documents/archival records

Documents and material were collected on the following general topics:

- 1) The history of midwifery in Australia and in NSW.
- 2) The organization of health care in Australia and in NSW, including maternity services.
- 3) Reviews of maternity services and policy documents related to women's health.
- 4) National policy statements, standards of practice and the code of ethics for midwives.

This material provided the general background in which to set the case study of midwifery.

A more detailed and focused collection of data was required for NSW. Information was collected in three main areas: education, regulation and practice and included:

- 1) **Regulatory Structure:** Copies of the most recent Nurses Act which contained the specific clauses pertaining to the practice of midwifery; other pieces of legislation relating to midwifery.

- 2) Education: Guidelines for midwifery education and core competencies (See Appendix 1). Lists of all midwifery schools in NSW and samples of the curricula from a variety of hospital based programs as well as those which were being developed in university departments were collected.
- 3) Practice: Standards of practice and scope of practice documents, policies regarding visiting rights and accreditation of visiting midwives, general guidelines and policy documents related to the provision of maternity services.

A list of these resources are included in the bibliography.

Other relevant documentation gathered resulted from a review of all midwifery and nursing journals, conference proceedings and newsletters from the state and national midwifery associations for the past several years.

3.4.2 Site visits

Site visits were usually conducted in conjunction with interviews with midwives. They included observational visits to birth centres, teaching and community hospitals, suburban hospitals, private offices of independent midwives, and early childhood centres and finally, schools of midwifery. In some cases several visits were made to the same institution to observe the context of different areas of midwifery practice; for example labour ward, birth centre and midwifery clinics. Notes were kept on the circumstances of each site visit and included information on changes in the role of the midwife in the particular setting, as well as other relevant details.

3.4.3 Observational settings

I attended all the monthly meetings of the Executive of the NSWMA, the Executive meeting of the Australian College of Midwives Inc. held in Sydney, the Joint Birth Consultative Meeting in Sydney and the annual state conference of the NSWMA in Dubbo.

3.5 Selection of key informants

Informants were selected on the basis of their knowledge and expertise in midwifery and represented three main areas of the profession: education, administration and practice. The initial list of potential informants included the Executive of the NSWMA and faculty members of midwifery schools. Additional informants were added to the list during the course of the research process as the names of those active in the profession, whether as educators, researchers, policy makers or practitioners became known. Informants were also asked to identify other midwives who they felt would be appropriate key informants. In this way midwives themselves were used to expand the list of possible informants. Given the diverse nature of midwifery practice in NSW, every effort was made to select midwives from as many practice areas as possible and to include those who were working in rural and remote areas of the state. In total thirty-eight in-depth interviews were conducted.

3.5.1 The interview process

All potential informants were contacted and informed of the objectives of the research and their verbal consent to participate was obtained. The interviews generally took place in the informants place of work, and in some cases they occurred in conjunction with a site visit. In cases where it was not possible to conduct the interview in person, such as those with midwives who were working in rural and remote areas, the interview was conducted by telephone. Those informants who were interviewed in person were asked to sign a consent (see Appendix 2) and all verbally gave permission to having the interview tape recorded. The level of cooperation from midwives in the study was high, all those who were approached to be interviewed agreed to participate.

3.5.2 Interview format

The initial portion of the interview consisted of seeking the informants assistance with clarification of details or issues which had already been identified in the course of the research. Informants were also asked to briefly describe their history as midwives. The remainder of the interview focused on the autonomy of the midwife. Open-ended questions were used to illicit their view on the present level of autonomy of midwives in NSW and in their place of practice if appropriate. They were also asked to identify factors which influenced this degree of autonomy and to identify the major barriers to midwives preserving or extending their level of autonomy. A flexible structure for the interviews facilitated the addition of questions and allowed for more in-depth exploration of some issues. An example of the interview format is provided in Appendix 3.

Most of the interviews were one to one and one-half hours in length and in a few cases, certain informants were interviewed a second time if one hour proved to be insufficient. Some informants were contacted by telephone following the interview if further clarification of details or issues was required. Additional field notes were also kept on each interview.

In total, 38 in-depth interviews were conducted and the informants were selected from the following areas:

Education:

Heads of schools	3
Lecturers/Clinical Teachers	6

Practice:

Hospital Based	10
Birthing Centre	5
Independent Practice	5

Administration:

Senior Public Health Officials	2
Directors: Area/City Health Authorities	3
Hospital Administration	3
Nurses Registration Board	<u>1</u>
TOTAL	38

3.6 Data analysis

The primary data sources for the project consisted of existing documents, interviews with key informants and notes based on observations from the field. The process of first organizing and then analyzing each data source required a different approach.

3.6.1 Documents/archival records

Photo copies were taken of all relevant documents and records. The organization and sorting of the information occurred according to the framework outlined in Appendix 4. Under each broad subject heading were additional subheadings which identified issues or related topics which required supporting data. Documents were reviewed, sorted and organized according to the main subject and related sub-headings. A system of cross referencing was also required in cases where one item of information proved to be relevant to more than one subject area.

3.6.2 Field notes

Field notes were also reviewed and categorized in the same manner according to subject heading and incorporated into the file. This supplemented the material already obtained from other sources. In addition, relevant details contained in the transcripts of the interviews were also added to the subject file. As a result each subject and sub-topic area often had data from all three sources.

3.6.3 Key informant interviews

The first step in the organization and analysis of the interviews was the transcription of the audio tapes to computer files. After extracting any relevant details which were related to general topic areas (ie. historical details, other details regarding regulation, education, and practice), the content of the interview transcript was reviewed in-depth. The main objective of this content review was to identify common themes and categories of information contained in the interviews. From this analysis, five major areas of information emerged. All contained a characteristic message or theme which related to the central concept under study, that of the autonomy of the midwife. Linkages between the themes were identified, creating a converging pattern of relevance around the central concept of professional autonomy.

For example, many midwives spoke of the importance that the loss of the total spectrum of midwifery skills had on the ability of midwives to function in a primary care role. Thus, one component of autonomy ie. the boundaries of the job or scope of practice was influenced by the degree to which midwives felt they had lost skills they felt were essential to meeting the requirements of the job. This theme of "Lost Skills" contained several related issues including: the relationship of fragmentation in the role of the midwife to the loss of skill and professional confidence, the displacement of "hands on" skills by those involving the use of technology and finally, the weakening of professional boundaries due to the loss of midwifery skills in certain areas.

The overall framework interpreting the themes was provided by the conceptual framework used for the project which was theoretically informed by a review of the literature.

3.7 Ethical considerations

A consent form for the interviews was developed (Appendix 2). All informants who agreed to be interviewed were asked to sign this consent. All complied with this request and in those cases where the interview took place by telephone, the consent was read and the informants verbal acceptance obtained. Informants were additionally informed that they would not be named in the report and other identifying information such as place of employment would be altered.

3.8 Limitations and sources of bias

One limitation of the project was that I was not able to travel to all areas of the state including the remote regions to undertake site visits and personally interview midwives working in these areas. In most cases, these interviews were conducted by telephone which limited my ability to establish a relationship with the informant and could have inhibited a more spontaneous expression of thoughts and ideas. A greater understanding of the issues, and indeed the questions to be asked, could have been facilitated if the context in which the midwife works could have been seen. Having a mental picture of this context would have added to the richness of the descriptions of the diversity of practice.

One potential limitation of the study relates to the generalizability of the research findings. In designing the project I was aware that questions about external validity or generalizability are central criticisms of qualitative data (Marshall and Rossman 1989). Two strategies were used to strengthen the studies generalizability. The first was triangulation in which information from a number of different sources was brought to bear on a single point, that of the changing role and autonomy of the midwife. For example, as issues emerged from a review of documents or archival material they were included in the interview format for key informants. Here they could be further clarified and developed more thoroughly.

The second strategy involved the use of a relatively large number of key informants. In recognition of the complexity and diverseness of midwifery practice in NSW, informants were selected from all segments of the profession, thereby enhancing the representativeness of the views expressed. Informants themselves were also used to identify other key individuals within the profession who could provide the view of midwives whose area of expertise was similar to their own. Both strategies strengthened the generalizability of the project.

In summary, utilizing a case study design, this research project sought to study midwifery in NSW. The project involved an examination of three main components of the profession: regulatory structure, education and practice. Issues related to the professional autonomy of midwives from the viewpoint of midwives in NSW was an additional research objective the project sought to examine through the use of in-depth interviews with midwives.

The following chapter will provide the context for this study of midwifery in NSW by describing the history and current organization of the health care system in Australia.

CHAPTER FOUR

4.0 The Australian health care system: an overview

Midwifery in Australia is integrated within a health care system whose unique history and current features form the larger context for contemporary midwifery practice.

This chapter will provide an overview of the history and main features of that health care system and is based on more extensive works by Dewdney (1989), Davis and George (1988), Palmer and Short (1989). The chapter will begin with a brief discussion of the similarities and dissimilarities between Australian and Canadian health care systems. The organization of perinatal services and the manner in which midwifery is integrated into the Australian health care system will be described in detail in Chapter Six and Seven of this thesis.

4.1 Background

Aboriginal Australians had for centuries used an elaborate system of plant remedies and ceremonial activities to combat illness and promote health. The first organized health service was introduced to Australia with the inception of the NSW colony in 1788 (Dewdney 1989). The role of government in the provision of health services at this stage of Australian history was significant. It held the total responsibility for the provision of health services for convicts and the military who formed the majority of the first settlers to Australia. By the end of the 19th century the delivery of health care had evolved into a combination of public and private provision which was similar

to the mixed system which prevailed in England at the time. Within this system, the government had the primary responsibility for essential environmental services such as water supply and waste disposal, as well as the regulation of some health related matters such as food standards and working conditions. Government shared the responsibility for the provision of basic hospital care for the ill with private charities and religious organizations. Private practitioners of medicine, dentistry, and midwifery, among others, provided services to those who could afford to pay either directly or through insurance schemes such as those provided by the Friendly Societies and hospital contributory schemes (ibid).

In 1901, when Federation occurred, the new Commonwealth government assumed only one specific area of control in health care, that of quarantine. Over the next 40 years the Commonwealth government remained relatively inactive in the area of health with the exception of providing a health service for ex-military service personnel. The state governments retained much of the legislative and regulatory power regarding health and the health care professions with some responsibilities being delegated to local government authorities. The actual provision of health care services remained much the same as in the pre-confederation era.

The current health care system in Australia has evolved into a structure where the sponsorship of health care is divided between the public and the private sector with varying levels of support and control. It can best be described as a two tiered system where government provides a basic universal health service in the form of Medicare and a public hospital system. In addition, those who are able, may purchase further health

care insurance in order to receive additional services and benefits beyond the basic medical and hospital services. The features of this system will be described in the remainder of this chapter.

4.2 Power and responsibilities in health care

4.2.1 The role of government

Public responsibility for the funding and delivery of health care services in Australia is shared among the Commonwealth, state and local governments. These three levels of government share power in three main areas; funding, the provision of services and the regulation of health services and health personnel.

4.2.1.1 Health care funding

The Commonwealth government has the primary responsibility for the funding of health care services in Australia. Since 1942 it has held the income tax powers, and therefore collects the bulk of the revenue which finances the health care system. Funding for health care is provided both directly and indirectly. Direct funding is provided for hospital, medical, and pharmaceutical benefits in each state. These funds are made available in accordance with the terms of Medicare Agreements which are negotiated between the Commonwealth and State governments on a regular basis. The Commonwealth government also subsidizes specific health related activities of non-governmental agencies such as those of the Red Cross blood collection service and health research funded by the National Health and Medical Research Council. State governments finance

health care from revenue obtained through the Medicare Agreements and other Commonwealth health grants which may be made for specific purposes (e.g. alternate birthing services funding). These funds are supplemented from state revenues in order to provide hospital, community and other services for the population in each state.

Local governments provide limited health care services which are funded by both the State and Commonwealth governments. The role of local government in the provision of health care is primarily related to the delivery of public health services such as immunization and the regulation and monitoring in areas related to public health, such as water quality, sewage disposal and food standards.

4.2.1.2 The provision of health care services

The state governments hold far greater powers of legislation related to matters of health when compared to the Commonwealth government. The responsibility for the development and delivery of health care services lies with each state government. One consequence of this division of power has been that no two states have developed their health care systems in the same manner leading to differences in how services are organized and delivered in each state. The development and quality of some health services varies from state to state and the degree to which there is community involvement in the development of health care policy also differs across state boundaries (Dewdney 1989).

4.2.1.3 Regulation of health services and health care providers

The regulation of health services and health care personnel is also a state responsibility in Australia. State legislation controls both public and private hospitals, nursing homes and matters related to the public such as occupational health, and food, drug and safety standards.

The registration and regulation of the health professions including medical practitioners, dentists, pharmacists, nurses, midwives, and chiropractors is also a state responsibility. Although the criteria for registration generally allow for portability of professional qualifications among the states, differences in the regulation of health professionals may result in variation in the practice of these practitioners in each state.

4.3 The role of the private sector

The private or non government sector of the Australian health care system can be divided into two components. The first operates according to business principles, seeking to earn a profit from the sale of health related goods and services. This component includes private hospitals and nursing homes, the pharmaceutical industry and the private practice of health professionals. Although this component operates in the private sector, income for goods and services rendered in part comes from government sources. As Dewdney (1989) suggests, this reliance by the private sector on government funding, ensures a measure of compliance with the policy intentions of the government.

The second private sector component in the health care system is made up of agencies and organizations which do not aim to produce a profit for their investors. Included here are private hospitals and nursing homes run by religious and benevolent bodies and volunteer agencies who provide education, support services and research into health related matters. These non-profit agencies also may derive some or all of their funding from government either as payment for services provided or by way of grants for approved activities.

4.4 Health care costs

The cost of maintaining the health care system in Australia was 20 billion dollars for the year 1985-86 which represented 8.3% of the Gross Domestic Product (Australian Institute of Health: Information Bulletin 1988). Revenue for health care is derived from three main sources, a Medicare levy of 1.4% on all taxable income, Commonwealth general revenues, state taxes and private sector sources. Since 1980, the cost of health care in Australia has been redistributed from the private to the public sector with the Commonwealth and State governments now providing approximately 75% of the funding for health care (Davis and George 1988). This can partially be explained by the introduction of Medicare in 1984, as well as an increase in the number of Australians who are eligible for additional subsidies because of unemployment, sickness and supporting parent beneficiary status (*ibid*). The difference in the amount collected from the Medicare levy and the cost of funding the universal health service is made up from general government revenue sources.

4.4.1 Pattern of expenditures

Institutional services including hospital and nursing homes make up the majority of expenditures on health care in the public sector. The next highest category of expenditures is non institutional services such as salaries. A small proportion of health care expenditures are spent on health promotion and research. The following table illustrates health expenditures in Australia for 1985-86.

Health Expenditure, Australia, 1985-86

Services or Goods Supplied	Percentage of Recurrent Expenditure, 1985-86
<i>Institutional Care: Total</i>	\$54.3
Public hospitals	\$34.4
Private Hospitals	5.7
Mental health institutions	3.9
Nursing homes	8.6
Other (ambulance services etc.)	1.7
 <i>Non-institutional care: Total</i>	 \$40.1
Medical services	\$18.1
Dental services	5.4
Other professional services	3.4
Community health services	2.8
Pharmaceuticals	8.4
Medical appliances	1.7
Other non-institutional	0.4
 <i>Other health related activities: Total</i>	 \$5.6
Health promotion and illness prevention	0.9
Research	1.4
Administration	3.3
Total	100%

SOURCE: Australian Institute of Health: Information Bulletin. Health Care Expenditures

A great deal of expenditures on health remain in the private sector such as dental and self-medication expenses. Here the "user pays" principle prevails and private health insurance may provide some coverage.

Like many other Western countries, the control of health care costs are a major concern for all levels of government in Australia. The reason for the growing cost of providing health care services are complex and involve issues which relate to the concentration of health care dollars in expensive acute care services, the role of service providers in determining patterns of treatment and the patterns of utilization among consumers of health care services (Sax 1989; Davis and George 1988). As Davis and George (ibid) note, the medical profession has a great deal of autonomy in influencing the pattern of expenditures in health care by its freedom to determine treatment and diagnostic practices. In addition, consumers have come to expect a certain standard of treatment which involves the extensive use of medical specialists and a range of diagnostic technology. Other sources of excess health care costs include over-servicing by service providers and inappropriate use by the public (ibid). Concern over rising health care costs has resulted in some restructuring of the health care system in many states and a general trend toward the rationalization of health care services.

4.4.2 Health insurance: public

The move to provide universal health care by government began in Australia in 1939 with a Labour government platform which included a commitment to provide a range of prescription medicines to the population free of charge. This move was opposed

by the medical profession who interpreted it as the beginning of the nationalization of medicine in Australia (Dewdney 1989). The ensuing conflict between the government and the medical profession culminated in a constitutional amendment in 1946 which allowed the Commonwealth government to extend its powers to include the provision of pharmaceutical, sickness and hospital benefits as well as medical and dental services. Also included in the amendment was a condition which disallowed any form of civil conscription which was allegedly added to safeguard the interests of the medical profession (ibid). The effect of this condition is that physicians cannot be forced by the Commonwealth government into providing particular services or accepting salary rather than fee for service payments. The right to extra bill for services is also maintained. While this amendment was significant in that it extended the constitutional power of the Commonwealth government into matters of health, it also secured the rights of private medical practice. The result has been that the dominance of the medical profession within the health care system has been maintained and the public control of the health care system has been significantly constrained (Davis and George 1988, Willis 1989).

A National Health Act was proclaimed in 1953 and enabled government to provide medical and hospital insurance benefits to the entire population of Australia. The manner in which these government sponsored benefits have been made available varied in the 30 years following and are currently provided by Medicare, the national medical insurance system which includes the public hospital system, which was introduced in 1984. Under the Medicare system, medical, hospital and allied health services are provided universally to all citizens. Medicare was created by a Labour government in accordance with basic

ideological principles which included "fairness in that contribution to costs are made in accordance with the ability to pay: affordability, in that costs to the individual are subsidized, and simplicity in that complex procedure for determining eligibility are eliminated and standard benefits can be easily understood by the public" (Sax 1989: 111).

This system has been successful in providing a health service in keeping with these founding principles but it is not without limitations. These include: not having the physician of choice for hospital services, waiting lists for some elective surgeries, limited choice in the level of hospital accommodation and finally, only essential health care services are covered under the Medicare scheme. Under Medicare, citizens are allowed to choose their physician for medical services outside hospital. They have the choice of physicians whose policy is to "Bulk Bill" or one who does not. The policy of "Bulk Billing" means that the physician will submit a bill for 85% of the Medicare schedule fee directly to government, and the patient will not pay directly for the medical services provided. Those physicians who do not "Bulk Bill" will charge the patient directly for the full schedule fee, and the patient will be reimbursed for 85% of that schedule fee.

Under Medicare, patients are not allowed to have their physician of choice in hospital and those who attend outpatient hospital clinics, such as for antenatal care, often experience long waiting times for appointments and a lack of continuity in medical care. There are also long waiting times for some diagnostic procedures and elective surgery within the publicly funded health service. As well, not all services provided by health professionals in private practice are covered by Medicare, including those of physiotherapists, chiropractors, naturopaths and midwives. Some services provided by

these practitioners may be partly covered by private health insurance funds. In order to overcome some of the limitations and inconveniences of the services provided by Medicare, some Australians chose to purchase private health insurance which covers them in part for services beyond those of Medicare.

4.4.3 Health insurance: private

In 1990, 52% of Australians were covered by some form of private health insurance (Australian Bureau of Statistics 1990). Private medical insurance provides some of the features which Medicare does not, mainly choice of physician in hospital, prompt treatment for elective surgery, preferred accommodation in public hospitals and finally, coverage for extras which may include services provided by non medical practitioners such as dentists, physiotherapists, psychologists, and naturopaths. Most private insurance companies do not cover the services provided by midwives who work outside the publicly funded system.

The cost of private medical insurance will vary according to the type of service provided. Coverage ranges from basic to top hospital cover which includes accommodation and services in hospitals and other ancillary services. In general, private medical insurance will pay a portion of the difference between the Medicare fee and the full amount charged by the physician or institution and will provide the patient with a choice of bed accommodation in both public and private hospitals. Many choose private insurance coverage to ensure prompt treatment for elective and non-emergency surgery if they or their family should require it. However, since private medical institutions and

the medical profession retain the right to set fees, even those with top private insurance cover may still pay if they choose hospitals and physicians who set rates higher than those covered by private insurance companies. According to a health insurance survey conducted by the Australian Bureau of Statistics (1990), the most frequently reported reasons for having private health insurance were security/peace of mind (40%) and choice of doctor (37%).

4.5 Hospital services

Australia has a mixed system of public and private hospitals. Hospitals are designated as such according to legislation in each state. The primary difference between the two classifications is that public hospitals receive the majority of their funding from the state or territorial government and are open to anyone who is in need of the in-patient or outpatient services it provides. In contrast, private hospitals do not receive any government subsidies and have strict admission policies, excluding the public at large. Hospitals run by benevolent or religious organizations on a non-profit basis but who have a restrictive admission policy are designated as private institutions.

The majority of public hospitals provide general medical and surgical services and in most cases provide obstetric, gynaecological and paediatric care. The range of services increases in the system from basic services offered by small rural hospitals to a wider range in district, base and suburban hospitals with 200 to 300 beds. Large teaching hospitals in urban areas may have 400 or more beds and offer a wide range of

specialist treatment and diagnostic services. A few hospitals specialise in one form of care, for example maternity and gynaecological care, or paediatrics.

In general, private hospitals offer a more limited range of medical and surgical services but offer prompt admission for the diagnostic procedures and elective surgeries they provide. All emergency and long term intensive care services for both paediatric and adults are available only in the public hospital system.

4.6 The division of labour in health care

An overview of the division of labour in the Australian health care system shows differentiation on the basis of skill, status, power and gender (Davis and George 1988). At the top of the hierarchy is the medical profession who enjoy a high social status in Australia and who are a powerful and highly paid professional group (Willis 1989). The ratio of physicians to the population is one of the lowest in Western countries. This ratio differs from state to state and from urban to rural areas (Davis and George 1988). In general, physicians tend to be concentrated in urban areas and the problem of recruitment and retention of medical practitioners in rural areas is ongoing. The profession is segmented into specialist and generalist practitioners and into public and private income sources. While the majority of the medical profession are paid on a fee for service basis, there is a growing trend for specialists to combine income sources and become salaried full time members of staff in public hospitals and as such are granted limited rights of private practice in that institution. As a result there is a mix of public and privately insured patients in some public hospitals. Physicians are the main professional group

who are allowed provider numbers which enables them to be paid on a fee for service basis by the Medicare system. They also have the freedom to set their own fees and their interests are well represented by their professional association, the Australian Medical Association (AMA). The AMA has developed its own fee schedule and some physicians bill in accordance with these rates which are higher than those of the Medicare schedule (Nelson 1993).

Of the 300,000 people employed in health occupations in Australia, over half that number are nurses. Despite their large numbers they occupy a lower position in the health care hierarchy. The majority of nurses are salaried and are employed in hospitals, community and occupational health settings. Their salaries are comparable to those earned by nurses in similar North American health care settings. Dewdney (1989) suggests these salaries are low in light of the level of responsibility and education that is required by nurses to work in an increasingly complex health care system. Nursing in Australia has been characterised as a profession which is attempting to realise its potential power in the health care system (Short and Sharman 1989).

Three recent changes reflect this current struggle. The first occurred in 1983 when a national referendum of members of the Royal Australian Nursing Federation resulted in the removal of a no-strike clause in their constitution. The second occurred in 1984 when the Commonwealth government announced that nursing education would be transferred completely from hospitals to the Colleges of Advanced Education. NSW was the first to implement this change and in 1985 entry to nursing through hospital training schools ceased. The third historically significant event was a fifty day nurses

strike in Victoria in 1986 when over 170,000 nurses walked off the job in protest over delays in the resolution of industrial claims. As Short and Sharman (ibid) observes, the occupational struggle of nurses in Australia represents two contradictory tendencies, professionalization and proletarianization. This view is consistent with others who have studied current issues facing Canadian nurses (Coburn 1988).

When one considers gender in the division of labour in health care, it is apparent that while females form the majority of the workforce, it is males who are concentrated in decision making positions such as medicine. Men are also more often in self employed occupations such as pharmacy, optometry and chiropractic. Women in contrast occupy lower positions in the hierarchy and more often are in secondary roles such as nursing. Within the medical profession, women make up 18.9% of physicians but are under represented in specialist areas. There are few women in high status specialties such as surgery and more in psychiatry and paediatrics. Women physicians also report lower incomes than do their male colleagues (Davis and George 1988).

4.7 Population health status

In Australia, as in most Western countries, there has been a steady rise in life expectancy at birth in the last 50 years: from 64 for males in 1935 to 72 years in 1983. The corresponding figures for women were 69 years in 1935 and 78 years. This improvement reflects the marked drop in infant mortality rates from 50 deaths per 1,000 live births in 1935 to less than 10 per 1,000 in 1985 (Better Health Commission 1986).

The improvement in life expectancy from age 45 is less remarkable: an increase of 2 years from 1935 to 1983 for men, and 5 years for women.

The major causes of death for middle aged and older Australians are ischemic heart disease and neoplasms and for those Australians under the age of 44, accidents, poisons and violence are the major killers. Deaths due to infectious diseases have declined markedly in the post war period but emergence of AIDS has brought to light the continued threat of infectious diseases.

Generalizations about the patterns of health and illness in the Australian population must be balanced with the fact that there are significant differences in the health status of certain segments of the population. The most striking example of this is in the Aboriginal population. After adjusting for differences in the age structure of the population, Aboriginal mortality ranges from twice that of the total Australian population, for Aboriginals in the remote Kimberley region of Western Australia, to approximately four times as high in country areas of NSW (Thomson 1989). Estimates of life expectancy for Aborigines vary, with the best levels being 61 years for males and 65 years for females (ibid). In all areas the major causes of death for Aborigines were diseases of the circulatory system, including ischemic heart disease followed by those due to accidents, violence and poisoning. The mortality of Aboriginal infants, despite improvements over the last 10 to 15 years, remains on average three times higher than for non Aboriginal Australians (ibid). After allowing for the higher birth rate among Aborigines, the maternal mortality rate was 3 to 5 times higher than that of other Australians in 1982-1984, the last triennium for which data was available (ibid). Finally, the

hospitalization of Aborigines is 2 to 3 times higher than non-aborigines and 5 times higher for children less than 5 years of age (ibid).

4.8 The distribution of health care

Universal access to health care was a fundamental principle which led to the formation of a publicly funded health care system in Australia. However, the distribution of health resources and therefore access is unequal on the basis of geographic and "moral evaluation" (Davis and George 1988).

Demographic changes have been cited as one reason for the inequality in the geographic distribution of health resources throughout Australia (ibid). At the time of Federation, the population of Australia was more evenly distributed in rural and urban areas. In the 1930's, a period of hospital construction occurred in rural areas through a shared program of Commonwealth and State government incentives. However, as a result of industrial development and immigration, the population has now become concentrated in urban areas and around seaboard cities. Consequently, the need for hospital services in rural areas has declined. The current situation reflects a need for a redistribution of hospital resources from rural to urban areas. In contrast, the rural areas have an undersupply of medical practitioners and experience on-going problems of recruitment and retention of medical personnel.

In the remote areas of the country, the Flying Doctor Service provides emergency and limited acute care services to a population which is scattered over a large geographic area. Other programs have also been developed specifically for the remote areas such

as the government funded Patient Travel and Accident Assistance Scheme which enable sick persons to be accompanied to the city for treatment. The general problem of service delivery to remote areas of the country and in particular the provision of services to pregnant women have been highlighted in recent reports (Report of the Working Party on the Care of Pregnant Women in Remote Areas 1984, Ministerial Task Force on Obstetrical Services in NSW 1989). Access to specialist services which are concentrated in urban areas and large teaching hospitals is also difficult for the population who live in the rural and remote areas of the state. Initiatives by government to more equitably redistribute health care resources have been met at times with opposition by health care providers who have already established their own patterns of service provision (Davis and George 1988; Dewdney 1989).

Equality of access is also influenced by the priority given to certain needs by decision makers and by society at large (Davis and George 1988). As a result, equal access by certain groups and for certain medical conditions cannot always be guaranteed. Several examples are offered by Davis and George (*ibid*) to illustrate this point. They include the special needs of the multicultural community which have only recently been recognized by health policy makers despite 30 years of major immigration. As well, the contrast between the health of Aboriginal when compared to that of white Australians has only recently been seen as a problem worthy of extensive government investigation and funding.

Priority also appears to be given to certain areas of medicine such as maternal and child health when compared to more controversial health issues such as abortion (*ibid*).

Other women's health issues are also less recognized and less likely to be supported with funding (Government of Australia: Women's Health Policy Report 1989). Finally, technologically complex medical specialties area also appear to be highly valued in Australia (Davis and George 1988; Palmer and Short 1989). Australia is among the leaders of research into reproductive technology and organ transplantation both of which consume a high proportion of health care dollars. In contrast health promotion, public health education initiatives have received a far lower proportion of the health care funds.

4.9 Summary

This overview of the Australian health care system reveals some basic similarities between the Australian and Canadian systems of health care. Both countries provide a universally accessible and publicly funded health care service. Within this system, the central government has assumed a primary role for funding health care services through a system of agreements with the provinces/states. Australia is different than Canada however, in the extent to which this funding arrangement is dependant upon compliance with the terms set by the central government.

In Canada the flow of funds from the Federal to the provincial governments is subject to the principles of the Canada Health Act-accessibility, portability, universality, comprehensiveness, and public administration and whose terms also do not permit extra billing or user charges. In contrast, in Australia, no such strict conditions apply to this overall funding arrangement, although the Commonwealth government will attach some

conditions on how the money is to be spent. The concept of extra billing is also an integral part of medical practice in Australia.

In both countries, the organization and delivery of health care services is the primary responsibility of the state/provincial government resulting in some variation in the regulation and practice of the health professions and the delivery of services in each state/province. The development of general health policy remains a state/provincial responsibility with the Commonwealth/Federal government having a peripheral role but nonetheless remaining influential by funding health related research through agencies such as the National Health and Medical Research Council in Australia and the National Health Research Development Program in Canada and the Medical Research Council. Both central governments also exert influence through the development of health policy guidelines that may be used to assist in the development of health policy at a state/provincial level.

Canada and Australia also share the challenge of providing health care services to rural and remote areas of the country and face similar problems of recruitment and retention of medical personnel to these areas.

The increasing cultural diversity of the population and the contrasting health status of the indigenous peoples in both countries is also an area of similarity between Canada and Australia. The pattern of health care expenditures in Australia parallels that of Canada as does the concern at all levels of governments over rising health care costs leading to health care reform in many parts of Canada and its Australian equivalent the "rationalization" of health care services.

In both countries physicians, remain the dominant profession in the division of labour in health care and remain the overall gate keepers to the health care system. Other health care occupations such as nursing having far less power and status.

The Australian health care system is most unlike that of Canada however, in its two-tiered structure of public and private health care where the government pays for a basic universal service, and those who have the financial means may purchase private health insurance to cover additional benefits and services. Australia is also unlike Canada in that care in childbirth by midwives is a service that is generally available within the health care system.

In summary, the particular challenges of providing health care in Australia include those which acknowledge the geographic diversity of the country, the differential health status of the population as well as the need to balance the interests of health service providers, health care institutions and the health care insurance industry. How midwifery is integrated into this complex system will be examined in detail in the remainder of this thesis beginning with the following chapter which will describe the history of the midwifery in Australia.

CHAPTER FIVE

5.0 Midwifery in Australia: an historical overview

5.1 Childbirth: an Aboriginal perspective

Although the primary purpose of this chapter is to describe the history of Western midwifery in Australia, it must be recognized that the indigenous people of Australia already had a well established system of beliefs and customs surrounding childbirth as well as their own traditional birth attendants prior to the white settlement of Australia.

Aboriginal beliefs about childbirth and their birth practices were deeply rooted in the Dreamtime, a complex cosmological belief system, and were practised in accordance with the Grandmothers Alukara Law (Abbott 1985; Devereux 1990). For Aboriginal people, childbirth was essentially seen as "women's business", and the overall approach to birth radically differed from Western beliefs and practices (Reid 1983). Abbott (1985) suggests that Aborigines approached birth or "Borning" not just as an act of labour but as an integral part of a wider symbolic process. "This process began at the time of conception in a particular area of the country, and was inseparable from the Dreamtime, the Law and the people, resulting in strong traditional affiliations, rights and responsibilities to that country (ibid:2).

Aboriginal women were attended at birth by other women skilled in the Grandmother Law. These women could be grandmothers, sisters or aunts. They performed the ceremonies and assisted the woman in accordance with the principles of

the Law. The following birth story illustrates the role of these birth attendants and highlights some of the features of the Grandmother Law.

They had been working together most of the night. The woman had left her husband's camp and gone to her grandmother when she felt the pains start.

Her grandmother, aunts and sisters prepared the Alukara-the women's camp. They build windbreaks around it for shelter and privacy, and fires for warmth. During the labour the women's female relatives stayed with her, keeping her company, talking to her and massaging her tummy. To begin with she walked about between contractions, stopping to lean on a tree during the stronger ones. When the birth was close, her grandmother helped her into the squatting position over a shallow hole lined with bark and encouraged her to push. The baby was born on the ground, on to her own country. She started to cry and her mother picked her up and put her to the breast. The grandmother was there to advise her and perform the ceremonies needed to help the baby and mother grow strong. The cord was cut with a stone in a special way, not too short and the placenta was buried close by. While the mother and the baby had a rest, the other women prepared special fires to smoke them. Special leaves were used which gave off medicinal smoke to stop the mothers bleeding, to bring in plenty of breast milk and to protect the baby and make her grow strong.

The new mother and her baby daughter stayed at the Alukura for about three weeks, looked after by the same women, fed good foods, nurtured and supported. More ceremonies were performed including the naming of the baby by the grandmother (Devereux 1990:21).

Like many other aspects of Aboriginal culture, the opportunity to maintain these traditional beliefs and practices surrounding childbirth was undermined in the two hundred years following the Western settlement of Australia. Attempts to assimilate Aborigines into the white Australian society resulted in the displacement of the traditional birth attendants and the Grandmother Law by western midwives, physicians and their approaches to childbirth. Following the introduction of health policy changes in the 1970's, even those Aboriginal women who lived a more traditional life in remote and isolated camps or communities, were evacuated to larger centres for delivery.

Despite these significant changes to this fundamental aspect of Aboriginal life, the Grandmother's Law is still very much alive and Aboriginal women are now asserting their desire to integrate the Law into contemporary childbirth practices. Issues related to their efforts will be discussed elsewhere in this thesis.

The remainder of this chapter will provide an overview of the history of Western midwifery in Australia and is based on more extensive works by Adcock (1984), Barclay (1985), Sullivan and Weitz (1988), Willis (1989), and interviews conducted for this study.

5.2 The development of midwifery in Australia

The initial development of Western midwifery in Australia was influenced by the British origin of those who first settled the country. Willis (1989) suggests that the decline in the role of the midwife in Britain had already begun prior to the settlement of Australia. He concludes that the transition in the attendance of childbirth from midwives to formally trained male physicians and the fixed position of midwifery as a lower status occupation was already established in Britain prior to the colonization of Australia. Many other factors however, were to influence the subsequent development of the midwifery in Australia. They include the involvement of the government, the timing of regulation, the power and influence of the medical profession, and the geographic realities of health care delivery in Australia. These developments will be described in several historical periods.

5.2.1 The convict era

The First Fleet of 11 ships arrived in Australia in 1788. Among the 1350 people aboard were 191 convict women and 33 marine wives. Historical records do not indicate whether any midwives were among the First Fleet which marked the beginning of the white settlement of Australia (Adcock 1984). The need for midwifery services in these early years was great. In the first 50 years of settlement more than 11,000 women were transported to Australia to redress the imbalance of the sexes in the colony. Free settlers also arrived in this period, attracted by the government's promotion of economic opportunities in the new colony.

The first maternity institution in Australia was at the "Female Factory" in Parramata, NSW (ibid). The Female Factory was established by the Governor both to provide work for female convicts, and to serve as a place where the sexes could be separated. Female convicts who worked in the community, primarily as domestic help for settlers and military families, were also sent to the Female Factory to be confined. Fertility rates among these women were high and a number of female convicts became midwives out of necessity. The mortality rates among infants born to the convict women were very high and the living conditions for these women were severe. Life was also difficult for women settlers who became pregnant. Adequate housing was scarce and so some were forced to live in huts or tents around settled areas. These women were assisted in childbirth by their neighbours, and at times by Aboriginal women in the area who acted as midwives. Most women helped each other out in time of need and physicians were only called in the case of emergencies.

By 1820, records indicate that a convict was employed as a resident midwife at the Female Factory in Parramata (ibid). A second Female Factory was established in Hobart, Tasmania during this time and women from this factory began to provide midwifery services to the more affluent women of the community. The first formally trained midwife in Australia, holding a diploma in midwifery from Edinburgh, opened a private midwifery service in Hobart in 1824 (Sullivan and Weitz 1988).

The transport of convicts to Australia ended in 1868, the Female Factories were closed and midwifery services moved exclusively into the home.

5.2.2 The pioneer era

By 1901 Australia had changed from a struggling penal colony with little in the way of government infrastructure, to a developing nation with a need for reformation in its social and economic organization. The success of the wool trade and the discovery of gold in 1851 had contributed to the increasing wealth of the country and also resulted in an influx of a large number of immigrants. This rapid growth of the population necessitated an increase in the numbers of physicians and midwives.

The majority of physicians who emigrated to Australia at this time had been educated in Britain and had emigrated to Australia in search of better economic prospects. They were generally from the middle class in Britain and to them Australia represented a less competitive environment, a less rigid social structure and a better economic future (ibid). The British middle class background of most 19th century Australian physicians had a significant influence on the development of midwifery.

Willis (1989) argues that unlike the more elite and affluent members of the profession in Britain, who opposed training in obstetrics for physicians, those who emigrated to Australia had few reservations about attending women in childbirth. As a result, training for attending births was included in the curriculum of the first medical school in Australia in 1862. This was more than 20 years earlier than it occurred in Britain, when in 1886 the elite of the medical profession ended their opposition to its inclusion.

During the second half of the 19th century, physicians established lying in hospitals in Sydney and Melbourne. Their primary purpose was to service the poor, and to provide a site for medical students to gain clinical experience in childbirth. Training programs for "ladies monthly nurses" were also established during this time (Adcock 1984). These monthly nurses acted as trained assistants to physicians who attended the home births of wealthier citizens, and as their name suggests, they stayed with these women for a month, providing care and assistance with domestic duties. Some monthly nurses expanded their role to include attendance at birth and set up midwifery services out of their residences. This early form of independent midwifery practice was strongly opposed by physicians. The service was in demand in the community however. Many of these practices became well established and were successful, despite the disapproval of the medical community.

By this time the settlement of Australia had extended into the rural and outback regions, far from medical services of any kind. Many who settled in these areas were very poor and times were difficult, especially for the women. The particular hardship which these families experienced was increasingly recognized by the Australian public.

As a result, the need for midwives in the rural and remote parts of the country was strongly supported by the general public and more reluctantly by physicians. As Sullivan and Weitz (1988) suggest, this was an important period in the history of midwifery in Australia. The geographic and economic realities of life in Australia during this time, combined with continued close ties to Britain, where midwives were more established, combined to ensure that physicians opposition to midwifery did not eliminate midwifery in Australia. While the geographic and economic influences in Canada at the time were similar, the powerful influence of the United States (where the practice of midwifery was actively opposed by medicine) may have been a contributing factor to weakening British influence on the development of midwifery in Canada and adding ultimately to its demise.

5.2.3 Regulation and incorporation

The first program to provide formal education for midwives began in Sydney in 1870 and was soon followed by the establishment of a similar program in Melbourne. Both were based on the Nightingale nursing model. The content of these early programs was both academic and practical. Their hierarchical structure was also evident, as physicians lectured on the science of obstetrics and nurses provided training in nursing and domestic duties. Willis (1989) suggests that this early formal basis of midwifery education in nursing facilitated the eventual incorporation of midwifery into nursing.

The enactment of midwifery registration in Britain in 1902 stimulated debate about whether or not a similar act should occur in Australia. While some physicians supported

the registration and regulation of midwives, most opposed it. Some physicians did not support the regulation of midwives because of the potential difficulty of providing enough registered practitioners for the rural areas of the country. Others saw it as a way of increasing the strength of midwifery by legitimising it as an occupation (ibid).

Nursing was beginning to seek occupational recognition through formal regulation at the time and increasingly regarded midwifery as part of its occupational territory. The regulation of midwives therefore, was opposed by nurses on the basis that it would create a separate occupation and weaken their own argument for registration (ibid). Despite opposition from both groups, the first Midwives Act was passed in Victoria in 1915. The control of midwives by physicians was very much evident in this first Midwifery Act. The regulatory board which governed the practice of midwives was made up primarily of physicians and did not include midwives. Unlike physicians, registered midwives were required to pay a fee upon registration and extensive limitations were also imposed on their practice. Despite this increasing control by physicians however, midwives remained independent of nurses. This period of relative independence ended in the years between 1920 and 1928 when the separate midwifery boards were eliminated and the control of midwifery came to be vested in the various nursing boards in each state (Barclay 1985). Willis (1989) suggests that while expediency was the primary reason offered for the dissolution of separate midwifery boards, the combined efforts of nursing and medicine were the main force behind the successful elimination of a separate regulatory structure for midwives. This period in the history of midwifery in Australia was significant in that it represented the ultimate subordination of midwifery (ibid). This

process was initiated first by the limitation of midwifery practice by regulation and finally by incorporation into nursing which was already located in a position of subordination to medicine. Willis concludes:

By becoming in effect, a special branch of nursing, something the leaders of the occupation of nursing encouraged as a strategy in their own attempts at professionalization, midwifery changed its structural position within the health division of labour from an independent status to a subordinate one. (ibid:93)

Despite formal regulation and control by nursing, entry to midwifery training was still available for non-nurses, and practising midwives who were not nurses were encouraged to take the opportunity to improve their knowledge and skills through programs of instruction offered by maternity institutions. However, it increasingly became customary for midwives to be educated first as nurses. This was reinforced by the fact that career advancement in nursing was often tied to the acquisition of a second qualification such as midwifery (Barclay 1985).

As the preceding discussion has suggested, the development of midwifery in Australia in the beginning of this century was influenced by a number of factors, including the relationship of midwives with medicine and nursing. The links of midwives with both nursing and medicine appear to have strongly influenced how the practice of midwifery was to evolve. Both medicine and nursing appear to have been successful in facilitating a change in the role of the midwife from that of an independent practitioner to a more subordinate role. Both also gained from this process. The efforts of nursing in seeking occupational recognition were strengthened as midwifery became incorporated within its scope of practice. Efforts to gain a wider and more dominant role in the care

of women in childbirth by medicine were also enhanced by the successful subordination of midwifery and its incorporation within nursing.

5.2.4 Post World War I influences

Initiatives by the Commonwealth government following World War I were also to influence the development of midwifery in Australia. The growth of the capitalistic economy at the time was believed to be dependant on the quality and quantity of the workforce (Willis 1989). During this time, however, the birth rate in Australia was declining and maternal and infant mortality rates were high. Maternal and child welfare therefore became a national priority for the government.

In order to encourage families to have more children, and to subsidize the cost of obtaining trained assistance in childbirth, a national program of financial assistance was established by the Commonwealth government. The "Baby Bonus" as it was called was available only to white families and was given regardless of financial need. The program was opposed by physicians on the grounds that it would increase the use of midwives in childbirth. Midwifery practice at the time was often characterised by physicians as unscientific and unsafe (Willis 1989). Midwives were also publicly accused by the medical community as being major contributors to the high rates of maternal and infant morbidity and mortality (ibid). The Baby Bonus in fact did not increase the use of midwives, but had the opposite effect. In the decade following the introduction of the program, the proportion of births attended by midwives was halved throughout the country. While the program appeared to encourage the use of physicians in childbirth,

their attendance did not have an appreciable effect on the rates of puerperal fever or an infant and maternal mortality. Willis (*ibid*) points out, the false linking of unfavourable birth outcomes with midwifery practice was slowly realised. Significant reductions in these rates were only observed after the principles of antisepsis were adopted by physicians, in addition to the introduction of antibiotics.

By 1936, 80% of births in urban areas of NSW had a physician attending or supervisory capacity (Adcock 1984). The situation was different in rural and remote areas of the state where midwives continued to practise extensively. One example was the Bush Nursing Service which was established in NSW (*ibid*). This service, which was analogous to the Frontier Nursing Service in the United States, provided midwifery services to many remote areas of the state. In many cases, the midwife was the only trained medical person available to the population of these isolated areas. Similar services were also established in other states and with the development of the Flying Doctor Service, these midwives were able to function with the backup from physicians.

In addition to practising in remote areas of the country, midwives continued to provide care in private cottage hospitals. In both of these settings, the midwife enjoyed a considerable degree of autonomy. Many of these small cottage hospitals closed during the Depression for economic reasons and during War II due to staff shortages. After the war their use fell further as they lacked the medical technology that was increasingly considered to be necessary in modern childbirth (Thornton 1972). The demand for home

birth also declined significantly during this period as the Australian public came to accept the view that birth in hospital was safer and preferable to birth at home.

5.2.5 Post World War II influences

By 1950, almost 100% of births in Australia occurred in hospital, a move that occurred two decades later in Britain (Tew 1990). Midwives followed women into hospital and continued to deliver the majority of women in public hospitals (Hayes 1992). However, the care they provided was now more subject to the supervision of physicians and, as salaried employees of institutions, their autonomy was further limited as their work became increasingly subject to the structure of policies and procedures dictated by their institutional employers. The organization of work in these institutions resulted in fragmentation of midwifery care and increased specialization of midwifery into one or more aspects of maternity care. This loss of autonomy for Australian midwives was offset by improved working conditions which were achieved as a result of unionization by nurses in the 1930's. Many of the remaining small maternity units or lying-in hospitals were closed during the 1950's despite the fact that they provided continuity and personalised care, features which were becoming difficult to obtain in larger maternity institutions (Adcock 1984). The 1960's and 1970's saw the rise of obstetrical practice in Australia and a parallel increase in the medicalization of birth (Lumley and Ashbury 1980). The numbers of obstetricians multiplied during this time and changes to medical care insurance provisions made it increasingly possible for women to have a physician for antenatal care rather than attend a hospital clinic where they would receive care by

a midwife (Adcock 1984). Childbirth preparation during this period also emphasised the importance of adequate nutrition, a modest weight gain and stressed the importance of regular antenatal care by a physician to ensure a healthy outcome (ibid).

Antenatal care now increasingly involved a wide range of tests and routine investigations, reinforcing the prevailing view that childbirth was an illness that required medical surveillance and hospital confinement. Birth in hospital was also subject to increasing intervention in the form of routine induction, elective caesarian and operative delivery. Intrusive and restrictive labour ward practices also became commonplace (Lumley and Ashbury 1980). In the 1970's public concern over the excessive rates of intervention became evident as did the demand for alternatives in childbirth including a renewed interest in home birth.

With the exception of the few midwives who began to attend home births during the 1970's, there was little left in the way of independent territory for midwives during this period (Barclay 1985). Increasing regionalization resulted in the closure of smaller maternity units and the introduction of policies which called for the evacuation of women in remote parts of the country, reduced the need for midwives in the outback.

5.2.6 The 1980's - a time of change

Studies of the midwives' role in hospital during the late 1970's and 1980's revealed that midwifery skills were frequently under utilized and were subject to increasing specialization (Barclay 1985, Kilver 1976, Stenning 1989). This significant erosion in the role of the midwife by the 1980's led some to observe that midwifery in

Australia now more closely resembled obstetrical nursing than midwifery (Barclay 1985, McDonnell 1991). In the absence of any national policy for midwifery, differences in the education of midwives and the limits imposed on their practice emerged between states (Barclay 1985). The review of nursing acts also began during this period and revealed a trend toward the erosion of the exclusive territory of midwives by nurses who did not have training in midwifery.

Other developments in the 1980's however, brought more positive changes to midwifery throughout Australia. First, midwives began to organize themselves as a distinct professional group separate from nursing, and began to see the benefit of having strong national leadership. The Australian College of Midwives Inc. (ACMI), which began as a special interest group of the Royal Australian Nursing Federation in the late 1970's, became a separate professional body in 1983. It now represents the interests of midwives at the national and state level. In the last ten years, the ACMI has been successful in raising the professional profile of midwifery in Australia, and has established formal links with the associations which represent Obstetricians and General practitioners (Birth 2000, 1991). Additional accomplishments of the ACMI include the development of standards of practice, an accreditation process for midwives in independent practice (ie. midwives who are not salaried by institutions but who work in private practice) and the creation of policy positions on all aspects of childbirth and professional practice. Midwives in Australia also gained the respect of the international midwifery community by hosting a very successful International Congress of Midwives Conference in Sydney in 1984.

In the 1980's health policy reviews at both national and state levels articulated women's discontent with many of the features of the existing system of childbirth care and highlighted the desire of some women for care by midwives throughout childbirth (Women's Health Policy Review 1989). These were followed by reviews of maternity services in some states which further emphasised the need for change in childbirth practices and a return to a wider role for midwives.

Finally, the beginning of a process that would change the primary site of midwifery education from the hospital to a university environment began in the 1980's.

5.3 Summary

This overview of the history of midwifery in Australia has shown that the role of the midwife has evolved from that of an independent practitioner at the time of the settlement of Australia, through a period characterised by a significant loss of professional autonomy, to the present, where midwives are attempting to regain a more autonomous role. This evolution in the role of the midwife has been influenced by a number of factors. These influences are complex and in many cases inter-related. They include, the rise in power and authority of the medical profession over midwives and the process of birth itself. The increasing involvement of medicine in childbirth which facilitated a greater application of science and technology to the management of birth and encouraged relocation of birth from home to hospital. Both factors resulted in a divergence of skills between midwives and physicians, facilitating a further erosion in the role of the midwife. This process was reinforced by the influence of gender and the

overall subordinate status of women (nurses and midwives) to men (physicians) in Australian society (Willis 1989). Finally, the emergence of a desire by women to de-medicalize the birth process combined with their emerging political power in Australia has brought greater recognition to midwifery and strengthened the professions to achieve greater occupational autonomy. This case study of midwifery in NSW will highlight many of the contemporary issues that effect the profession as a whole, and will describe changes in the role of the midwife in NSW that are shared by many midwives throughout Australia. These issues will be explored in greater depth in chapter seven of this thesis, which will provide a more extensive examination of contemporary midwifery in NSW. The following chapter will provide a description of NSW, where the study took place.

CHAPTER SIX

NSW: A DESCRIPTION

This chapter will provide a brief description of the geography and population features of NSW, the organization and delivery of perinatal services, and other information related to the provision of health services for childbearing women.

6.0 NSW: an overview

6.1.1 Geography, population and climate

NSW is one of six federated states which together with the Australian Capital Territory and the Northern Territory constitute the Commonwealth of Australia. Within the State there are three levels of government: the Commonwealth with specific powers derived from the constitution, the State government with residual powers and local government with powers based upon a State Act of parliament. NSW was the site of Captain Cook's original landing and of the first permanent white settlement in Australia.



FIGURE 2 Map of Australia

The total area of the state is 801,600 square kilometres which represents one tenth the area of Australia. NSW is Australia's most populated state and has the country's largest city, Sydney. In 1992 the population of NSW was 5.9 million (Australian Bureau of Statistics 1992).

Natural features divide the state into four main zones, extending from the north to the south. The narrow Coastal Region extends from the Queensland border south to the border of Victoria. This region is 80 kilometres wide in the north and 30 kilometres wide in the south. A low range of mountains, the Great Dividing Range lies just inland from the coast and extends from one end of the state to the other. The pastoral Tablelands extend west from the Great Dividing Range followed by the fertile farming region of the Western Slopes. The Western Slopes fade into the Western Plains, the NSW version of the Australian outback. The Western plains which comprise two thirds of the area of the state are dry, barren and scarcely populated.

NSW is situated entirely in the temperate zone, the climate is mild and generally free from extremes of cold and heat. The range of mean temperature between the hottest and the coldest month in Sydney is 11 degrees Celsius. The average rainfall varies between 2,000 mm in parts of the North Coast to 200 mm in the far Western region of the state.

Despite its large area, NSW has a highly urbanised population with 74% of the population living in centres of 20,000 or more. The population of NSW was 5.9 million in 1992 which is 34% of the total population of Australia. Fifty five percent of the population or just over 3 million people live in Sydney, 5% live in Newcastle the states

next largest city, followed by 4% in Wollongong and 3% in the cities of the central Coastal Region.

Prior to World War II, Australia had a strict immigration policy which limited the numbers immigrants entering the country, particularly those from non-white countries. Following the war this policy was lifted, resulting in an increase in immigration from countries of Eastern Europe and the Middle East. In addition, in the last twenty years, Australia has accepted a large number of refugees from Asian countries, particularly Vietnam. Many of these immigrants to Australia have settled throughout NSW adding to the cultural diversity of the population.

After Queensland, NSW has the highest Aboriginal population in Australia. In 1986, the Aboriginal population was 59,013 which represented 1.1% of the total population of NSW (Australian Bureau of Statistics 1986). The age composition of the Aboriginal population in NSW, like that of the total Australian Aboriginal population, differs markedly from the age composition of the total Australian population. Forty percent of Aborigines in NSW are under the age of 15 years, compared with 23% of the total Australian population. While 15% of the Australian population are over 60 years, less than 4% of Aborigines live longer than 60 years. The Aboriginal population in NSW, like the rest of the population, has followed a trend of increasing urbanization.

6.1.2 Economy, population health status

The major part of the labour force in NSW is employed in the wholesale and retail trade followed by manufacturing, agriculture and mining. In 1992 just under 10% of the

population in NSW were unemployed (Australian Bureau of Statistics 1992). The average weekly income for workers in NSW was A\$651.95. At the time of this study NSW, like the rest of Australia was in the midst of an economic recession which began in 1990.

In general, the citizens of NSW enjoy a high level of health as reflected in the life expectancy of 80 years for females and 73 for males. However, the rates for the Aboriginal population stand in marked contrast to these figures. In 1981 the life expectancy of Aboriginal males was 51 years and for females it was 57 years. The major causes of death in the total population are diseases of the circulatory system, the major one being ischemic heart disease. This is followed by malignant neoplasms for the non Aboriginal population and in the Aboriginal population by Accidental Injury and Poisoning (which includes accidental deaths and deaths due to violence).

6.2 Funding and organization of health services

The responsibility for the provision health care services in NSW lies with the State government. The budget for the NSW Health Department in 1992 was A\$3.098 Billion. The state finances its health care expenditures through its own sources of revenue, mainly by taxation. In addition to state generated revenue, grants are received from the Commonwealth government for general purposes and capital expenditures. In 1992 these grants from the Commonwealth government totalled A\$18 million. In some cases, short term grants are made for specific purposes such as the Commonwealth sponsored Alternative Birthing Services Program which made available A\$400,000 to the State

government for the establishment of alternative birthing services which included the establishment of Birth Centres staffed by midwives.

The remainder of this chapter will provide additional details relevant to the organization and delivery of health care services for childbearing women.

6.3 Organization of perinatal services

NSW is divided into a total of 16 health areas and regions. The highly urbanized part of the state which primarily includes the city of Sydney and its suburbs, is divided into 10 health areas. The remainder of the state is comprised of six health regions.

Perinatal services vary within each area and region and are classified according to the guidelines provided by the Ministerial Task Force of Obstetric Services in NSW (1989). In general, the classification of hospitals providing perinatal care are determined by physical facilities and on the availability of medical and midwifery personnel. A description of the classification of obstetric hospitals in NSW is provided in Appendix 4. Most women in NSW deliver in Level Four facilities (38%) which provide both in-patient antenatal and delivery services and have full time obstetrical, paediatric and 24 hour anaesthesia coverage.

In 1989, there were 135 maternity units in NSW of which 63 had fewer than 80 births per year. Most births occurred in public hospitals (92%) with 7% occurring in the six private maternity hospitals. Private maternity hospitals are generally classified as level three institutions and do not provide services for high risk confinements or for infants who require long term intensive neonatal care. Private hospitals are staffed by

salaried midwives who provide care in labour and immediately post-partum. Home deliveries represent about 1% of the births in NSW are primarily conducted by independent midwives.

For antenatal care, women who are not covered by private health insurance attend hospital clinics which are staffed by salaried physicians. Midwives do participate in these clinics but their skills are significantly under-utilized (Stenning 1989). The most notable exception are those institutions which offer midwives clinics (midwifery practice will be examined in-depth in Chapter Six). Those women who have private insurance, see the obstetrician of their choice for antenatal care. A small number of women receive antenatal care by their general practitioner who may share care with an obstetrician (usually for delivery). These shared care arrangements are more characteristic of rural rather than urban areas of the state.

Some hospitals which are classified as public institutions provide delivery services to women who hold private health insurance, in addition to those who are covered by Medicare. In 1987, just over one half of women in NSW held private health insurance which covered childbirth services including the services of a private obstetrician antenatally, delivery by a private obstetrician and hospital accommodation, the level of which varied according to the degree of cover purchased (Ministerial Task Force on Obstetric services in NSW 1989).

The organization of maternity care post partum is similar to that of antenatal care, with women either returning to hospital clinics or to their private obstetrician for care following delivery. Community based programs such as that of early postpartum

discharge and neighbourhood baby health centres also provide nursing and midwifery services. These programs will be discussed in greater depth later in the next chapter.

6.4 Care of women in remote/isolated areas

Women who live in remote and isolated parts of the state do not have the benefit of having readily accessible health services while pregnant. Many receive antenatal care from the Flying Doctor Service (which may include some care by a midwife) or travel to a larger centre to see a general practitioner or obstetrician if available. All are evacuated to larger centres late in pregnancy and with births occurring in the local hospital. Upon discharge they return to their community with post-partum care once again being provided by the Flying Doctor service or by a general practitioner in the nearest country town.

6.5 Care of Aboriginal women

There is no separately organized system of perinatal care for Aboriginal women in NSW, with the exception of the Aboriginal Medical Service (AMS) which is available in some areas of the state. This medical service is run by Aboriginal people and provides a comprehensive primary health care service. In areas where there is no AMS, or women will receive antenatal care at the local hospital outpatient clinic, or from a general practitioner or community health clinic. Those who live in isolated and remote parts of the state receive antenatal care from the Flying Doctor Service and are evacuated to larger centres for delivery. As will be discussed elsewhere, the care of Aboriginal

women in pregnancy is less than adequate and is one factor in the disparity between their health and that of non-Aboriginal women in NSW.

6.6 Workforce

In 1987 there were four hundred and sixty obstetricians estimated to be practising in NSW, of whom 14% were female and 13% were over 60 years of age (Ministerial Task Force On Obstetric Services in NSW 1989). Most obstetricians (74%) practise in metropolitan Sydney, primarily in the southern metropolitan area. The practice of some obstetricians includes both public and privately insured women.

General practitioners who provide obstetric services make up a very small proportion of the workforce and practise primarily in rural areas. There is a significant shortage of specialist neonatologists in NSW and insufficient training opportunities to meet future requirements (ibid). A severe shortage of specialist neonatal intensive care nurses also exists in NSW. Approximately thirty percent of registered nurses hold midwifery qualifications, however only 8.5% (3292) of those qualified practise as midwives (NSW Nurses Registration Board 1990). Further details regarding midwifery in NSW will be discussed in greater depth in the following chapter.

6.7 Facts about childbirth in NSW

Much of the information regarding childbirth in NSW is detailed in reports provided by the Perinatal Epidemiology Unit of the Department of Health. This Unit

began an extensive process of maternal and perinatal data collection in 1985 and this information has formed the basis of yearly reports provided by the Department. Midwives in NSW are largely responsible for the completion of the data base forms for the Collection, as it is called, an example of which is provided in Appendix 6. The information provided in this chapter will be largely drawn from the 1987 report.

6.7.1 Demographic information

In 1987 there were 1.27 million women of childbearing age in NSW. Of these women, an estimated 25,000 were overseas born and spoke little or no English. Eighty-four thousand were Aboriginal or Torres Strait Island women.

Eighty-five percent of childbearing women were between the age of 24 and 34 years of age, with 1% being over 40 and 5.6% under the age of 20. An analysis of fertility rates in non Aboriginal women indicate that the rate was decreasing in women under the age of 25 and increasing after 25 years of age. This trend however, was reversed for Aboriginal women. In the 15 to 19 year age group of Aboriginal women the fertility rate was four times that of the non Aboriginal population and in the 20 to 34 group it was twice that of the non Aboriginal population. After age 35 the rate was declining in Aboriginal women but showed an increase in the rest of the population.

In 1987, a total of 82,126 births occurred in NSW. The details regarding of 97% of these births were reported to the Maternal and Perinatal Data Collection.

6.7.2 Antenatal care

The results of the 1987 Maternal and Perinatal Collection indicated that 52.8% of women received antenatal care by a specialist obstetrician. Of the remaining number, 21.2% attended a hospital clinic and received care by the hospital medical staff, 20.6% saw a general practitioner, 4.8% had a shared care arrangement with a general practitioner/obstetrician, or midwife/general practitioner and finally, 0.3% attended a midwife for their antenatal care. Shared care arrangements between general practitioners and obstetricians appeared to be widely practised in rural areas of the state where the number of obstetricians is small compared to urban areas.

A small number of women, 0.9%, reported fewer than two antenatal visits with some regional variation. In some parts of the state this figure rose to 30%, particularly in areas with a large Arabic speaking population.

Twenty-eight percent of women received in-patient antenatal care for an average length of stay of 2.83 days.

Recently, NSW has adopted a policy of allowing women to carry their own antenatal care cards similar to the established system currently in place in Britain.

6.7.3 Delivery

Ninety-nine percent of births in NSW occur in hospital, with the greatest number occurring in Level Four institutions (54.1%). Planned home deliveries accounted for less than 1% of births. An analysis of home confinements was not provided as data regarding these births was provided to the Collection in less than 50% of cases.

Spontaneous cephalic delivery occurred in 67.7% of women. Slightly over half of primigravidas, 53%, had a spontaneous delivery as compared to 77% of multigravidas.

Operative deliveries occurred in 32% of births, with mid/low forceps occurring in 14.8% of cases. The caesarian section rate in NSW was 15.9% (elective 8.1% vs. emergency 7.8) which compared favourably to the overall Australian rate of 16.7%. As would be expected, the rate of spontaneous delivery was highest in hospitals classified at lower levels of acuity and highest in the referral centres in which the majority of high risk births take place. There was a degree of variation in operative delivery rates across hospitals with the same classification however, with the highest operative delivery rates occurring in private hospitals. Fetal distress was the most common indication for operative delivery followed by failure to progress, previous caesarian and breech presentation.

The over all rate of induction of labour in NSW was in 20.2%, with considerable variation occurring in among private and public hospitals. In general the rates of induction were higher in private hospitals when compared to public hospitals of the same classification. There was also variation in the induction rates according to the mothers country of birth. Women who originated from Asia and the Middle East were less likely than Australian born women to be induced. The rate of induction was 13.1% for Asian women and 12.9% for women of middle Eastern origin. Aboriginal women had an induction rate of 14.7% relative to 21.6% for other Australian born women. Labour was augmented in 17.4% of births but no data was available on the type of induction used.

Other information regarding routine interventions such as episiotomy and electronic fetal monitoring and other birth practices such as perineal shaves and enemas are not part of routine data collection procedures in NSW. Therefore, it is difficult to determine how widespread these routines and practices are. Based on the interviews and site visits conducted for this study, it was apparent that in general, the routine use of such procedures and practices was declining, there was considerable variation across institutions in this regard. Some institutions appeared to be committed to implementing some of the recommendations based on the available research such as that found in Effective Care in Pregnancy and Childbirth (Chalmers, Enkin, and Kierse 1989), in other institutions change was occurring much more slowly.

6.7.4 Maternal medical conditions/obstetrical complications

Medical conditions were reported in a small number of pregnancies in 1987. In the majority of pregnancies, 95.7%, no significant medical complications were reported. Essential hypertension, diabetes and asthma formed the majority of the conditions reported. The authors of the 1987 Maternal and Perinatal Report suggest that under reporting of medical conditions in pregnancy was thought to have occurred in the collection of this data, limiting the reliability of the reported figures.

Under reporting was also thought to have occurred in the area of obstetric complications (ibid) as the figures show that most women, (86.4%), experienced no complications of pregnancy. Pre-eclampsia was the most common obstetric complication

(5.2% of pregnancies), followed by pre-mature rupture of membranes (2% of pregnancies) and finally, antepartum haemorrhage was reported in 1.1% of pregnancies.

No formal risk scoring system for childbirth is used in NSW.

6.7.5 Birth outcomes

In 1987, the overall perinatal mortality rate for NSW was 10.4 per 1000 births. There was some regional variation in rates with the highest occurring in the Far West regions of the state. The rate for Aboriginal infants was 24.7 per 1000 births which is 2.4 times greater than the overall NSW rate and 2.6 times greater than the rate for Australian non-Aboriginal infants (9.6 per 1000). The perinatal mortality rates for infants of women who were born in the Middle East and Europe were 14 and 11 respectively. Infants born to women who attended less than two antenatal visits had a perinatal mortality rate of 33.8%.

Ninety-two percent of infants had a birth weight of between 2,500 and 4,499 gms with 5.8% having a low birth weight. The rate of low birth weight was highest in the Aboriginal population.

Five hundred infants died within the first four weeks of life and six hundred were stillborn. Four thousand and twenty premature deliveries occurred in 1987 and 1000 infants required ventilatory assistance for an average of 17 days. The neonatal mortality rate was 3.2 per 1,000 live births. The maternal mortality rate was 2.3 per 100,000 women.

6.7.6 Postpartum Care

Care of the mother and baby in the immediate postpartum period in NSW is most commonly provided within hospital maternity units. The average length of stay in hospital following birth in 1987 was 6.2 days. In areas where a demand for obstetric beds was high, the average length of stay was shorter and the development of early discharge programs by some institutions further decreased the length of stay. Care following discharge is largely provided by a network of professionals including early childhood nurses, midwives, physiotherapists, general practitioners and medical specialists. In hospitals with early discharge programs, midwives provide postnatal care to women in their own homes, women who discharged after a normal length of stay do not receive home visits by midwives. An extensive number of publicly funded neighbourhood baby health centres staffed by midwives and early childhood nurses, are utilised by a large number of women for support and advice on parenting and child development post discharge. Family care cottages also provide day care services for new mothers and parents with feeding, sleeping and child development problems. A small number of residential mothercraft units also provide intensive support and advice to women whose babies or children require special assistance with feeding or behavioral difficulties. A voluntary network of community based services such as the Nursing Mothers Association are also available to women who require information and support. Despite the wide range of services that appear to be available to women in NSW following birth the estimated incidence of significant postpartum depression is 15-20% (Ministerial Task Force on Obstetric Services in NSW 1989).

6.8 The ministerial task force on obstetric services in NSW

NSW was one of the first states in Australia to undertake a comprehensive, government sponsored review of maternity services. The Ministerial Task Force on Obstetric Services in NSW was struck in 1987 and over a period of two years undertook an extensive review of all aspects of the provision of maternity services and examined many of the issues related to childbirth from the viewpoint of service providers and consumers (Bennett and Shearman 1989). In an analysis of the Task Force, Walker (1990) suggests that the reasons for the establishment of the Task Force were varied. Women's dissatisfaction with many of the features of the current system of care in childbirth had been one of the principle findings of an earlier review of women's health policy in NSW (Report of the Womens Health Policy Review Committee 1985) and was also a major finding of a national review of women's health policy (National Womens' Health Policy Report 1989). Other reasons given were: a need to reform obstetric practices in general, a way to justify the redistribution of resources and a political move designed to win votes (ibid).

The Task Force was headed by a highly respected professor of obstetrics, Professor Rodney Shearman, which as Walker (ibid) concluded, guaranteed respect for the Review from his colleagues and the community. Membership in the Task Force was broad and included representation from the health care professions, consumers and the multi-cultural and Aboriginal community. The Task force received a total of 279 submissions from various individuals and organization, held consultations with the community and conducted a wide range of site visits.

The Final Report of the Ministerial Task Force on Obstetric Services in NSW, more commonly known as the Shearman Report, was released in 1989. The Report contained a comprehensive range of recommendations which involved all aspects of maternity services provision. In general, the recommendations called for a redistribution of obstetrical resources to areas of the state which were currently under-served, the need for improved services for low-risk birth and a more natural and flexible approach to childbirth. It also highlighted the need for mechanisms which would improve access and services for certain groups of women such as single and young women, Aboriginal and non-English speaking women and women who are isolated geographically. The report also acknowledged the importance of consumer input into the Review process, the need for improved education and support for childbearing families and the importance of monitoring medical intervention in the birth process. Finally, the recommendations of the Shearman Report clearly recognized the value of the midwives role in the care of childbearing women and in general, provided a policy framework from which changes in midwifery practice could occur. The recommendations which relate to midwifery in general and the role of the midwife relative to the needs of the Aboriginal and multicultural community will be discussed in greater depth in the following chapter.

In summary, the objective of this chapter has been to provide the context for this case study of midwifery in NSW. The following chapter will provide an in-depth description of midwifery in NSW including details regarding infrastructure of profession, the changing nature of midwifery practice and finally will highlight the goals and issues that currently face the profession.

CHAPTER SEVEN

7.0 Midwifery in NSW: a contemporary view

This chapter will provide an in-depth view of midwifery in NSW including its history, current organizational structure and educational system. The process whereby the profession has organized itself and developed strong network of midwives within the state will also be discussed. In addition, the diversity of midwifery practice will be described with a focus on the changes that within the health care system which have affected midwifery practice. The degree of autonomy that midwives have across practice settings will be a central element in this description. Finally, the issues and challenges facing the profession will be highlighted as midwives and their work are described.

7.1 The regulation of midwives

The history of the regulation of midwives in NSW parallels that of midwives throughout the rest of Australia. Until the later part of the 19th century the practice of midwives who were predominantly informally educated, was unregulated. These midwives cared for the majority of women and enjoyed a considerable degree of respect in their communities (Adcock 1984). The first attempt to control the practice of midwives through formal regulation began in 1894 with the efforts of a physician Dr. J. Graham who introduced a bill in the State Legislature which would have formed the framework for the education and regulation of midwives. There was not a great deal of support for his efforts and the medical profession appeared divided on whether formal regulation would increase or decrease the competition from midwives (Van Der Klei

1991). The Bill was also opposed by others on the grounds that there would not be enough registered midwives to fill the needs of the population in all areas of the state (Adcock 1984). Failing in this first attempt, Dr. Graham along with the Australian Trained Nurses Association, formed a midwifery subcommittee that established a mechanism for the voluntary registration of midwives (Purcal 1985, Love 1979). While this registration provided a way for midwives to increase their status through regulation, few took the opportunity. In 1901, 90% of practising midwives in NSW were unregistered and not formally trained (Van der Klei 1991).

Efforts to regulate midwives over the next 30 years were unsuccessful, until the passage of the Nurses Registration Act of 1924. As elsewhere in Australia, this legislation officially brought midwifery under the control of nursing. Midwifery ceased to be a distinct and separate occupational group from a regulatory viewpoint and the historical distinction between the two occupations became increasingly blurred from that time on (Willis 1989). The Nurses Registration Act of 1924 was replaced by a new Act in 1953 which also included provisions for the regulation of midwives or "midwifery nurses" as they were often referred to in practice. The practice of midwifery was still subject to specific conditions, and the distinct nature of midwifery practice was recognized by separate clauses, including those which dealt with domiciliary practice. Midwives also had provision for representation on the Nurses Registration Board and a separate register was also set up for midwives. However, some of the features which gave midwifery a distinctness within the regulatory structure of nursing were to disappear over the next 30 years. The conditions which related to domiciliary practice were

removed in 1975 and amendments to the Act in 1985 and 1987 eliminated the separate register for midwives as well as the specific provision for representation of midwives on the Nurses Registration Board (NSW Nurses Registration Board 1990).

The 1953 Nurses Registration Act was subject to a review by a Ministerial Working Party in 1990. In light of the changes that had occurred in the health care system since 1953, a review was considered necessary and appropriate. The primary aim of the review was to create a new regulatory structure that would reflect the reality of current nursing practice in NSW. The overall disciplinary provisions provided in the 1953 Act were also regarded as unsatisfactory (either too lenient or too severe), the efficiency of the Board required improvement, and finally the regulations regarding midwifery practice needed "tightening up" (Collins, 1991). More specifically the Department of Health and the Nurses Registration Board felt that the current regulations were not effective in prohibiting the practice of midwifery by non-registered midwives.

The 1953 Nurses Act stipulated that a person shall not practise midwifery unless that person is a registered nurse who is authorized to practise midwifery (Section 23 (2), 21 (4)). Exceptions were provided to:

- 1) Any medical practitioner.
- 2) Persons giving assistance in emergency situations.
- 3) Students of midwifery, nursing or medicine.
- 4) Where the woman did not reside within 20 kilometres of a medical or midwifery practitioner or appropriated practitioner is unable or unwilling to attend.

The latter provision was regarded as providing a way in which lay birth attendants, the majority of who practised in rural areas could practise midwifery and not be in conflict with the Nurses Registration Act.

Under the 1991 Act, the specific clauses related to the unauthorized practice of midwifery were revised and now include exceptions give to:

- 1) Medical practitioners.
- 2) Emergency situations.
- 3) Medical or nursing student or any accredited nurse acting under the supervision of a registered nurse who is authorized by the Board to practice midwifery (Part 2, Section 7 (2)).

The third clause gives non-midwifery trained nurses the right to practise midwifery under the supervision of a qualified midwife. The nature and extent of the supervision was not specified in the Act.

The changes to the sections of the 1991 Act that were relevant to the practice of midwifery were opposed by many midwives throughout the state and officially by their professional association, New South Wales Midwives Association. The objections of midwives related both to the process of consultation that occurred when the Act was reviewed and to the potential implications of the changes that related to midwifery practice. The NSWMA maintained the position that the consultation that had occurred during the drafting of the Bill had been ineffective, and that given the level of concern about the provisions for midwifery practice in the Act, specific representation by

midwives on the Working Party should have been provided (Haertch 1991). The opinion of both the Nurses Registration Board and the Department of Health was that proper consultation had in fact occurred (Phillips 1991).

The NSWMA and many midwives in the state opposed the Nurses Bill most strongly on the basis that it represented a serious threat to the future of midwifery practice and ultimately to the health and safety of mothers and babies (D'Elmaine 1991; Griffiths 1991; Haertch 1991; Robinson 1991). By authorizing unqualified practitioners (ie. non-midwifery trained nurses) the right to practise midwifery they argued, the Act erodes the exclusive right of midwives to practise midwifery and effectively opened the door for a cheaper and less qualified health care worker to enter into the occupational territory of the midwife (Griffiths 1991). Some argued that the new Bill effectively implied that there was no special skills or knowledge was required to practise midwifery (ibid) and facilitated a trend in which many nurses in leadership roles were to regard midwifery as just another specialty within nursing. The NSWMA also argued that the nature of the supervision stipulated in the clause was unclear, poorly defined and open to broad interpretation. Therefore, the Act placed undue responsibility on midwives to provide supervision of unqualified practitioners and that this would jeopardize the care of childbearing women.

These concerns expressed by the midwives were countered by the argument of the Department of Health and the Nurses Registration Board that the realities of current practice in the state, particularly in rural areas resulted in non-midwifery trained nurses looking after childbearing women and the inclusion of the supervisory clause in effect

made the situation safer because it now required supervision whereas it previously did not (Dent 1991, Meppem 1991).

Despite a vigorous media and lobbying campaign by the NSWMA to seek changes to the Act it was proclaimed in March of 1992. Since that time midwives have been successful in having a midwife elected to the Nurses Registration Board; however, their efforts to have the Act amended have thus far been unsuccessful.

Despite the implications that the 1991 Nurses Act has for the future role of the midwife in NSW, the right of midwives to function as autonomous practitioners is still maintained by the regulatory structure provided by the Nurses Act of 1990. In accepting the definition of the midwife adopted by the International Confederation of Midwives and the World Health Organization, the legal right of the midwife to provide care on her own responsibility in NSW is recognized by its regulatory body. Other states limit the autonomy of midwifery practice in a number of ways; for example, Victoria restricts the right of midwives to advertise and accept payment on a fee for service basis. There is also a legal requirement that the clients of a midwife also be under the care of a physician. There are no such restrictions placed on the practice of midwifery in NSW. Therefore, midwives in NSW are legally entitled to function with a considerable degree of autonomy in keeping with their recognized scope of practice. Whether or not the practice of midwifery reflects this relatively broad or enabling regulatory structure will be examined later in this chapter.

7.2 Professional organizations of midwives

There are two organizations in NSW which represent the interests of midwives. The NSWMA which is a branch of the Australian College of Midwives, Inc., is by far the largest with 1200 members. The Australian Society of Independent Midwives has approximately 30 to 50 members in NSW (Lecky-Thompson 1993).

7.2.1 The New South Wales Midwives Association (NSWMA)

In relative terms, midwives in NSW have only recently had the benefit of representation by their own separate professional association. For the majority of the time since formal regulation occurred midwives have come under the umbrella of various nursing association within the state (Hayes 1992).

The origins of the NSWMA can be traced back to the beginning of the century to the midwifery branches of the Australian Trained Nurses Association (ATNA). These early midwifery interest groups provided an opportunity for midwives to meet regularly to discuss matters of mutual concern regarding education, practice and legislation (ibid). The association with a professional nursing body continued until 1983 when the midwives in the state separated from their affiliating body, the Royal Australian Nursing Federation, to form their own midwifery association. The events which led up to this separation can be traced back to 1970 with the visit to Sydney of Margaret Myles the famous British midwife and her colleague Marjory Bayes. At that time, a process was initiated that would eventually lead to Australian midwives being granted membership into the International Confederation of Midwives (ibid).

It was at the International Congress of Midwives in Lusanne in 1975 that Australian midwives were first exposed to the antagonism that existed among their midwifery colleagues internationally towards nurses and desire by many to have a separate identity from nurses (ibid). This is best illustrated by the following:

Miss Margaret Porter, the Director of Nursing of the Royal Hospital for Women, Paddington in Sydney took her place and began to deliver her paper. Using nurse and midwife interchangeably, as was the current Australian fashion, she became very bewildered about the very, very long line of delegates who stood up to question her on the use of the terminology (ibid:17).

It was in this international context that Australian midwives began to appreciate the tenuous relationship between nursing and midwifery, the value of enhancing communication between midwives in all states and the benefits for midwives of having a national organization. In 1978 with only fifty members, the NSWMA became one of the founding members of the National Midwives Association which eventually was to become the Australian College of Midwives, Inc. In 1984, although the NSWMA had only 73 members, NSW was the host state for the 20th Congress of the International Congress of Midwives; an event which was an organizational and financial success. Since that time the activities and the membership of the association have increased considerably.

The NSWMA now has an elected executive board of 12 members, part-time executive and educational officers and in 1991 the association purchased official headquarters in Sydney. The Association has five active sub-branches which serve as a network for communication among midwives throughout the state as well as coordinating the efforts of the Association at a local level. The activities of the Association have

expanded to include the production of a quarterly newsletter, the provision of continuing education opportunities, the establishment of a midwives scholarship fund and a mechanism for ongoing liaison with the nursing and medical professions. As the state branch of the Australian College of Midwives Inc. (ACMI), the NSWMA also participates in the activities of the profession at a national level and has gone from being the smallest of the founding members states to the one whose members form the largest number of ACMI members. But most importantly, the Association has emerged as a strong and effective organization which now represents the interests of midwives and is increasingly consulted whenever decisions are made which will effect midwives and midwifery practice. The pride that many midwives expressed about their professional association is reflected in the statement by the following independent midwife.

You can't help but feel a sense of pride when you look at what the Association has accomplished in a very short period of time. We have gone from being a small group of very dedicated group of midwives to a strong professional body that is making its strength felt. If we find out that we have not been consulted when decisions are being made about midwives or health care for childbearing women we make a point of rectifying that situation.(K)

7.2.2 The Australian Society of Independent Midwives (ASIM)

As the name suggests, the ASIM is an organization for independent midwives throughout Australia (Independent midwives are those in private practice. For a more detailed discussion of independent practice see section 7.7). The total membership is approximately 150-200 (Lecky-Thompson 1993). Estimates of the number of registered midwives in NSW who are members of ASIM is between 30 and 50, and approximately five unregistered or lay midwives hold memberships (ibid). Many registered midwives

in independent practice belong both the ASIM and the NSWMA, although some only belong to the NSWMA.

ASIM was founded by a midwife from NSW and its national office is in NSW. The organization was started in 1989 as a result of the perception of some independent midwives that as a group with special needs and skills, they were not given consideration within the Australian College of Midwives and by implication the NSWMA. While both ASIM and NSWMA support improved maternity services for the women and upholding the role of the midwife, ASIM differs both in the origin of its membership and over all approach to change (Communique 1991). ASIM was started by a group of midwives who were considered by the rest of the profession (and indeed themselves) as being somewhat radical and who saw the need for significant changes both within the profession and with in the health care system in order to better fulfil the needs of women. While many of the midwives who formed the ACMI were midwifery tutors and came with strong academic backgrounds, those forming ASIM were practising midwives in independent practice (ibid). In the view of some ASIM members, they needed a separate organization which could provide support and communication, since the very nature of independent practice means that an umbrella of professional support from a hospital or other health care organization is unavailable to them.

While the primary aims of ASIM are to uphold the role of the midwife, and to work for improved services for childbearing women, ASIM has also become involved recently in the education of midwives. A program of midwifery education called the Midwives Academy was developed by members of ASIM and will be offered in 1993.

It will provide education for midwives who wish to enter into independent practice. The Academy is also available to practising midwives who wish to update their knowledge and skill in certain areas related to independent practice.

The Communique, the official newsletter of ASIM, is published four times per year and acts as a vehicle for communication between independent midwives throughout Australia.

In summary, despite changes to the regulatory structure of midwifery in NSW over a period of 70 years, the legal right of midwives to function autonomously had been maintained. The basic control of midwifery however, remains within the regulatory structure of the nursing profession. Despite the influence and control of nursing, midwives appear to be effectively organizing themselves in order to meet the distinct goals and needs of the profession. These changes are occurring at a time when system of education for midwives is undergoing a period of change. These changes will be discussed in the next section of this chapter.

7.3 Midwifery education

The history of the education of midwives is very closely tied to that of the history of the registration of midwives in NSW since education was to become the basis upon which registration was possible. Prior to the registration of midwives which began in 1925, the majority of midwives in NSW had no formal training although some educational programs had been available in the state since 1877. Despite the fact that much of the practice of midwifery occurred in the home and community, these programs

were hospital based. The influence of the Florence Nightingale philosophy and style of training was very much evident in these early educational programs, which stressed the subservient and supportive role to be played by midwives in relation to the physician. The initial basis of midwifery education in nursing was to influence the development of midwifery throughout Australia as previously discussed in Chapter Four. Some have speculated how the future of midwifery could have been shaped if these early models of midwifery education had followed the European tradition of midwifery education being separate to that of nursing, creating a distinctly and separate occupation (Barclay 1989, Willis 1989).

The first school for midwifery nurses, as they were often called, was established in Sydney in 1877 at the Benevolent Asylum which later became the Royal Hospital for Women (Adcock 1984). The number of hospital based schools increased in the years following as the trend for attaining formal education for midwives became the rule rather than the exception. By the time of the Nurses Registration Act of 1924, the number of untrained midwives had declined considerably and continued to do so until traditional midwifery had disappeared by the mid 1940's (Purcal 1985).

Entrance to midwifery training was possible through nursing and by direct entry. The training for non nurses was extended by several months (Love 1979, Nurses Registration Board 1990). However, although direct entry was possible, the majority of midwives were trained in both nursing and midwifery. Education in both disciplines was considered necessary for those who practised in rural and remote areas in the state where work involved caring for the ill as well as attending women in childbirth. Further

training in midwifery was the first related discipline where nurses were able to attain an additional professional certificate. This benefited those who wished to advance their careers in nursing, since promotion was usually given to those who held a double certificate (Barclay 1985). Although direct entry to midwifery education was possible in NSW until 1971, few midwives received their education through this option (Nurses Registration Board 1990).

The early education of midwives was conducted in both the hospital and community, with small lying-in hospitals providing the setting for domiciliary practice. However, as the trend to hospital delivery increased in the 1930's the opportunity for students to learn how midwifery skills were practised outside of a hospital environment diminished.

Since its inception with the initial regulation of midwives, the NSW Nurses Registration Board has set the regulations that determine the content of the curriculum and the clinical requirements for midwifery education. Prior to 1980 the Board also had the responsibility for setting registration examination and skills assessments for students, but the responsibility for the examination of midwives was then given to individual schools of midwifery. However, the Board still must approve all midwifery curriculum. The most recent guidelines regarding midwifery education were released in 1990 and outline the Board's philosophy of midwifery, the competencies that must be achieved and basic clinical requirements for student midwives (Appendix 1).

The education of midwives in NSW is currently in a period of transition between hospital and tertiary (university) based programs. With basic nursing education now

being provided totally in the tertiary sector in NSW since 1985, the move of midwifery education was considered by many to be both inevitable and desirable (Van Der Klei 1991). The need for improvements in midwifery education that would reflect a stronger academic focus were also supported by recommendations of the Ministerial Task Force on Maternity Services in NSW (1989) as follows:

That tertiary and professional colleges review the theoretical and practical training components of undergraduate and postgraduate, medical, midwifery/nursing and allied health professional programs to ensure that adequate attention is given to the development of communication, counselling and cross cultural awareness and technical skills relevant to normal and complicated pregnancy, childbirth and postnatal care (Recommendation 2.22).

The move of midwifery education to the tertiary sector was also supported by the Australian College of Midwives Inc. which recommended that the transition be achieved by 1995 following an "orderly transition" (ACMI Policy Statement 2.1.0, 1989). Despite this recommendation there is no organized plan for moving midwifery education to the tertiary sector as there was for nursing education in NSW. The reasons for this are not entirely clear.

A survey into the nature and conduct of midwifery programs throughout Australia by Hancock (1992) revealed a disparity among the states in the planning and implementation of the move, as well as a diversity of the type of degree given to graduates of existing programs. Hancock results indicated that NSW was the most advanced in terms of the transition to the tertiary sector. At the time of this survey, there were five university based programs in NSW offering programs in midwifery. Three of which were at a Bachelors level and 2 at a Graduate Diploma level.

A survey on the status of midwifery education in NSW was conducted by Van Der Klei in 1991. Results of the survey indicated that of the 24 hospitals in state which offered basic midwifery education, the majority either had no plans to discontinue their midwifery courses or had not yet entered into negotiations with a university Department of Nursing to take over their programs. Those hospital based programs who had started planning for relocation to the tertiary sector, were at different stages in the process of phasing out their programs. Some had already made plans to transfer all of their placements to the university, while others were at various stages in negotiations with universities. Although the hospital based program of midwifery education is currently being phased out in NSW, the hospital remains an integral part of the educational process and remains the primary setting where students learn the clinical skills of midwifery. While the content of midwifery programs may vary from one tertiary setting to another, some features will be common to them all. The academic portion of the program will be provided at the university level and will consist of courses which will also be offered to students undertaking post graduate course in other areas of nursing. The primary clinical component of the program will continue to be taught at an affiliated hospital.

The graduate diploma in Health Science (Midwifery) offered by the University of Sydney Faculty of Nursing is one example of a tertiary based program which will be offered over two years of part-time study. During the first year the student may be employed in any area of nursing and will take a combination of core (nursing) courses as well as basic midwifery courses. In the second year of the program, the student must be employed in an approved midwifery institution. During this second year the student

will learn and practise most of the skills required for midwifery practice. The student will graduate with a graduate diploma in midwifery which could be converted to a Master's with further study. (This is assuming that a basic baccalaureate degree in nursing is already held.)

It is also expected that the tertiary based programs will provide the opportunity to have some flexibility in the development of the curriculum content and will include courses which are considered important to midwifery students as they gain the knowledge and skills that will prepare them to function in a primary care role. In addition, there is now a potential for greater flexibility in choosing the settings where students learn the clinical skills required of a midwife. At the time when this research was conducted these programs were in the developmental stage, therefore the specifics which settings could be chosen had not yet been determined. However, based on the views of those interviewed, these settings could potentially include those serving a multi-cultural community, independent midwifery or birth centres, depending on the interest of the student.

7.3.1 Continuing education for midwives

While not a requirement for continued licensure, ongoing education is also available for midwives through courses provided by the NSWMA, the NSW College of Nursing and the Australian Society of Independent Midwives.

In March of 1992 the NSWMA, in response to growing request from midwives throughout the state, began a series of short courses in midwifery which were designed

to update practising midwives in the areas of teaching skills, physical assessment, research and management. The first midwifery refresher course NSW was also developed by the Association. This course is designed to meet the needs of those who are returning to midwifery practice or those who feel they are out of date with current midwifery practice and education. The midwifery refresher course combines classroom instruction with a self study approach and also includes a clinical component. These courses are offered in addition to regular half and one day courses in variety of topics. The Association also holds an annual one day conference.

The NSW College of Nursing offers certificate courses for midwives through their advanced nursing studies program. The program was developed in response to requests for post registration studies by many nurses including midwives, infertility and women's health nurses. The certificate program in Advanced Midwifery is funded by the NSW Department of Health and is available to midwives throughout the state. The students of the program came largely from country areas, reflecting the desire of rural midwives for more ongoing education (NSW College of Nursing 1990). The program is designed with a central core of topics related to women's health. Three specialties areas have been developed from this basic core curriculum: midwifery, infertility and women's health. A large portion of the program is designed on distance learning principles to accommodate the large number of requests from midwives in rural areas. The emphasis in this program is on broadening the midwives theoretical understanding of women's health issues, professional development and the value of research in midwifery practice rather than on the refinement of clinical expertise in midwifery (ibid). Courses designed

specifically for midwives in independent practice have been developed recently by the Australian Society of Independent Midwives. The curriculum for the Midwives Academy, as the program will be called, was developed in response to the demand for further training in the midwifery skills necessary for independent practice and will be complementary to the basic midwifery education programs now currently offered. The primary aim of this educational program is to provide midwives who wish to enter into independent practice with the opportunity to learn and practise the skills that will enable them to function autonomously and fulfil the international definition of the midwife (Communique 1992). The Academy will operate under the auspices of the ASIM, lecturers will primarily be midwives in independent practice. Students will have the opportunity to learn skills in nontechnical settings and in a variety of apprenticeship models.

To summarize, the educational system for midwives in NSW is undergoing a period of change. At the time of this study it was in a state of transition from a long tradition of hospital based training to one in which the midwife will now be prepared in both an academic and clinical environment. Opportunities for midwives to extend their education into the area of primary care are also developing. These changes are in keeping with the changing role of the midwife in NSW and are necessary to prepare midwives for the new opportunities in practice as they develop. The changing nature of midwifery practice in NSW will be discussed in the following section of this chapter.

7.4 Midwifery practice in NSW

The total number of registered midwives in NSW in 1990 was 18,960 (Nurses Registration Board 1990). This represents almost one third of the 70,299 registered nurses in the state but a relatively small proportion of those who qualify actually practise midwifery. The number of registered midwives employed as midwives was 3292, or only 8.3% of the total nursing workforce. Another 2.6% of midwives are employed in neonatal intensive care and mother craft (childbirth education). The Nurses Registration Board does not keep detailed statistics on the area of practice in which registered midwives work. However, statistics on both the type and place of employment were available from the NSWMA. The NSWMA had 1200 members in 1992, representing approximately 40% of employed midwives in NSW.

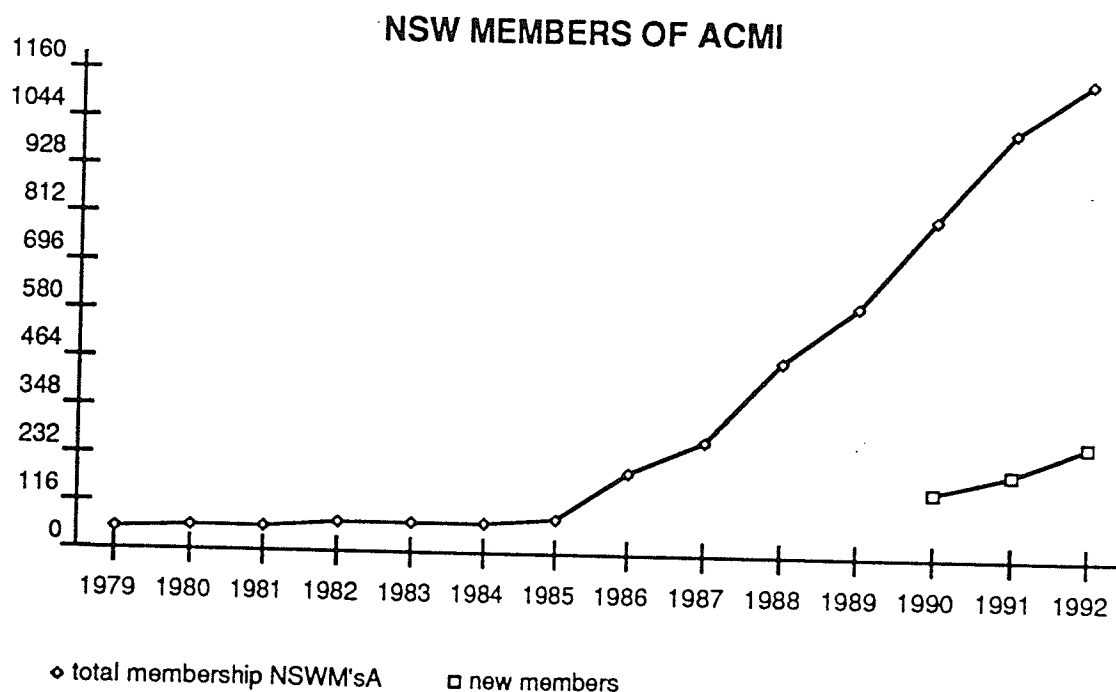
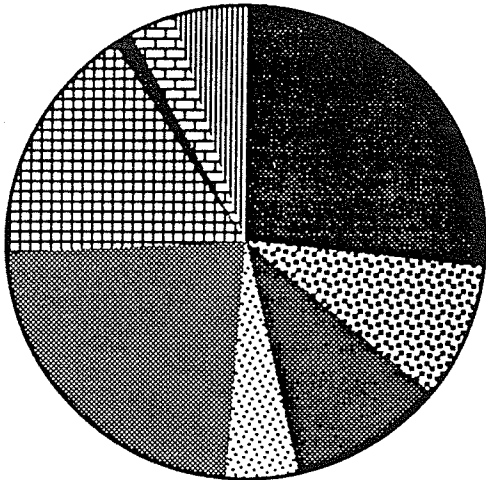


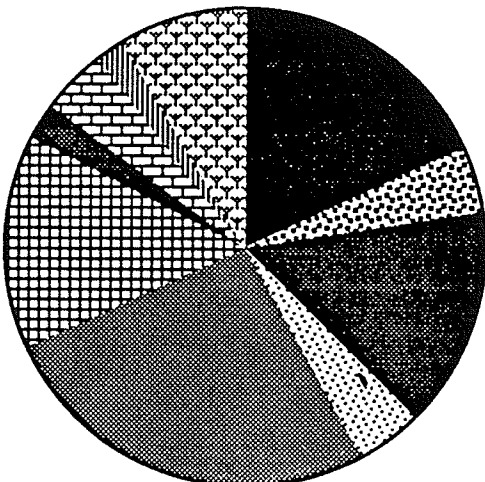
FIGURE 3 NSW members of ACMI

1992 - Place of Employment



Uni Teaching Hospital	26.7%
Private Hospital	9.0%
Rural Hospital	10.7%
Community Health Centre	4.7%
Suburban Hospital	22.9%
Country Base Hospital	16.4%
Private Domiciliary Practice	1.4%
University /CAE /TAFE	3.1%
Not recorded / other	4.9%

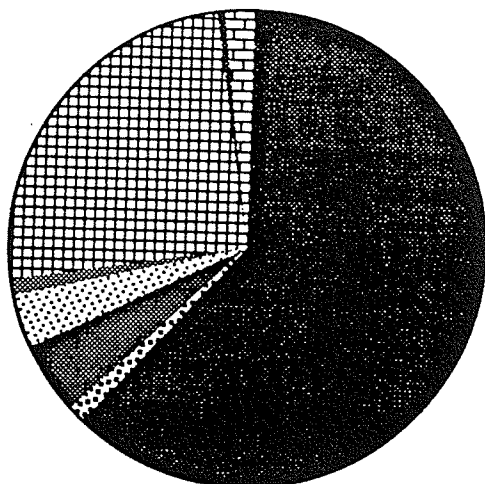
1988 Place of Employment



Uni Teaching Hospital	18.0%
Private Hospital	4.5%
Rural Hospital	15.0%
Community Health Centre	4.5%
Suburban Hospital	26.0%
Country Base Hospital	14.5%
Private Domiciliary Practice	2.5%
University /CAE /TAFE	4.5%
Childbirth Education Agency	2.0%
Not recorded / other	8.5%

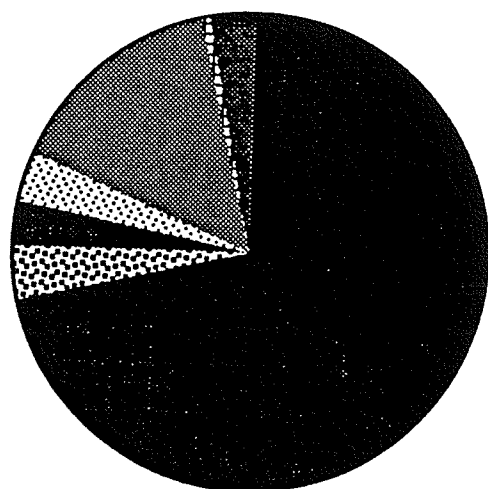
FIGURE 4 Changes in midwife's place of employment

1992 - Type of Employment



Full Time	61.7%
Casual	1.3%
Leave (maternity mostly)	5.0%
Not employed	3.4%
Not supplied/other	1.3%
Part Time	24.9%
Retired	0.5%
Self Employed	1.9%
Student Midwife	0.1%

1988 Type of employment



Full Time	71.5%
Leave (maternity mostly)	3.5%
Not employed	3.0%
Not supplied/other	3.5%
Part Time	15.0%
Retired	0.5%
Self Employed	3.0%

FIGURE 5 Changes in midwife's type of employment

7.5 Current models of midwifery practice

Midwifery practice in NSW can best be described as being in a state of change. As new variations in practice models have emerged, opportunities for midwives to expand their role and regain some their professional autonomy have increased.

The majority of midwives work within two main models, hospital and independent practice.

7.5.1 The hospital based model

Most midwives in NSW work within a hospital based model and are salaried employees. It is within this model that the greatest amount of variation in practice occurs. For example in one institution you may have a wide range of practice options for midwives, from labour and delivery, to clinical education, to early discharge programs or midwifery clinics.

The autonomy of the midwife within each variation of hospital based practice is also varied and is largely determined by the policies of the institution. In some hospitals, midwives are less constrained by policy and are more able to make decisions based on their own judgements. In others, midwifery practice is more subject to the control of institutional policy. As a result, there is a great deal of variation in the autonomy of midwifery practice across institutions often within the same city.

7.5.2.1 Unit based practice

In many institutions it has been customary for the midwives's role to become fragmented with specialization occurring in one area of maternity care. As a result, some midwives practice in one area only, working exclusively in a delivery, antepartum or post partum unit but not all three. Only a few institutions have policies which require that midwives rotate through all areas. The most notable exception are smaller maternity units, particularly those in rural areas, where it is customary for midwives to work in all areas.

Unit based practice has undergone significant changes in the last 10 years and in general, midwifery practice is now much less subject to the strict policies and procedures which were prevalent in the 1970's particularly in the delivery unit. The contrast in midwifery practice in the 1970's and the 1990's is described by the following excerpt from an interview with a one delivery suite midwife.

I trained in the late 1970's. Those were the days of big intervention. In this hospital we had an induction room with 8 beds that was staffed from 7:30 am to 10:00 pm every day except on the weekend. The midwives role at that time was to get them into labour in a hurry, so we had quick-fast inductions, with lots of syntocinon. We used lots of early epidurals, to keep the noise down...The main skill was to get them to almost full dilation, get them out of the induction room which involved getting an epiduralized patient onto the trolley wheeling the trolley and the IMED pump into the delivery room and onto a delivery table and have the doctor arrive just as the head was crowning...Now that was a skillful midwife! The whole practice of midwifery at the time was dictated by hospital policy which really was made by the VMO's (visiting medical officer)..it was very rigid ...Now it is different...things are more relaxed the place is the same but the skill in helping someone have a normal delivery and using your judgement is more recognized..we have a good deal of autonomy in the management of normal cases...back in the 70's we tended the machines and looked after the technology..now we diagnose problems and act..we often had to ask before. (I)

The degree of control over decision making that midwives in unit based practice hold is also influenced by whether or not the woman holds public or private insurance. In many maternity units in NSW there is a mixture of public and privately insured women. In the case of those women who do not hold private insurance, midwives will totally manage labour in uncomplicated cases, including the delivery and consult with the house medical staff only if required. In contrast, the midwives role in the care of those who hold private insurance is much the same as a labour and delivery nurse in Canada. The midwives will provide care in labour, keep the physician informed of the progress of labour, carry out their orders regarding the management of labour and inform them when the delivery is imminent. If the physician does not arrive in time for the delivery it will be conducted by the midwife.

In summary, at the unit level, in many maternity institutions the constraints on midwifery practice as dictated by policy appear to be decreasing. However, variation in the autonomy of midwives in unit based practice is still evident throughout the state in both rural and urban areas.

7.5.2.2 Midwives clinics

Since the establishment of midwives clinics in hospitals, midwives in NSW are again involved in the provision of antenatal care. This aspect of the midwives role had largely disappeared in the 1970's (Adcock 1984). Studies of what remained of a midwifery role in antenatal care in the 1980's indicated that the midwives skills were widely under utilised (Stenning 1989).

The selection procedure and management guidelines vary from one midwives clinic to another but generally this form of care is available only to low risk women. These hospital-based clinics are provided as an option to women by participating institutions, usually following an initial assessment by a physician. Women who attend midwives clinics generally have a repeat visit with a physician in the later half of pregnancy or as required. Midwifery-based antenatal care is also provided in the form of outreach clinics where midwives provide clinics in a particular neighbourhood or in some cases remote or distant communities as a way of increasing access for some women who would otherwise not seek care. Midwives clinics have also been successfully established for specific groups, such as adolescents who appear to benefit from the unique approach that midwives provide. The changing role of the midwife in the provision of antenatal care to Aboriginal women and women from the multicultural community will be discussed elsewhere in this chapter.

7.5.2.3 Early postnatal discharge programs

Postnatal domiciliary care programs are hospital based services which offer midwifery care to women who elect to be discharged within 24 to 48 hours following delivery. This option is not universally available to women throughout NSW and is provided only by hospitals who elect to develop such a program. The first program began in NSW in 1984 and in 1991 there were a total of 28 programs available throughout the state (NSW Department of Health 1991).

Under the program, women in pregnancy, are offered the option of early discharge and home midwifery postnatally subject to medical and obstetric screening. Midwives in the program begin their care of these women immediately post discharge and continue midwifery care and support in the home environment for a period of seven days and longer if required. Within this model the midwife has a greater degree of opportunity to independently manage the care of women postnatally with the general guidelines for care developed by the program. The success of such a model has been well documented both in terms of outcomes, cost effectiveness and job satisfaction for midwives involved (James et al 1987) . Eligibility criteria for the program is also being assessed, and in the future may include women who have had more complicated deliveries including caesarian section.

7.5.2.4 Birth centre practice

Birth centres are another variation within the publicly funded hospital system where midwives may now practice. The concept of birth centres was first introduced to NSW in 1979, but it was not until this decade that they became more widely available as a place to give birth and emerged as a practice setting which facilitated a more independent role for midwives. All birth centres in NSW are administratively linked to a maternity hospital. They are organized differently; however, the philosophy of Birth Centres appears to be consistent throughout the state. Several key elements appear to be common to all Birth Centres. These include: the recognition of the normalcy of birth, the importance of assisting women to deliver with a minimal amount of intervention, the

need to return the control of childbirth to women and to encourage their active involvement in pregnancy and birth (O'Donnell 1991). There is also consensus on the central role midwives play in supporting and assisting women at the time of pregnancy and birth.

In some cases the birth centre is located geographically separate from the labour and delivery unit. In others, they may be located directly next to the labour and delivery unit. Although the luxuriousness of setting varies, all birth centres have attempted to create an environment which is more home-like, quiet and in which technology is strikingly absent. The important contribution of a calm and peaceful environment, separate from the labour and delivery unit, to the birth process was summed up by one birth centre midwife.

The environment is very important in creating a feeling of safety for women as they labour..there should be a minimum number of intrusions, that is why I feel the birth centre has to be set apart from the delivery unit. If it is too close then you will get people, mostly doctors drifting in...that makes it harder for the women to concentrate and do their work and the midwife to do hers. (O)

Protocols for eligibility and the criteria for transfer of care also vary among birth centres with some restricting the service to women who are low risk, while the criteria developed by others makes the service available to women of low and moderate risk (O'Donnell 1991). Limiting the criteria for the birth centre to low risk women is also being challenged by those who believe that the features of the birth centre should be available to all women regardless of risk (Rowley and Saxton 1992). Recently a birth centre service is being made available to women of all risk categories in the Hunter Valley (ibid).

Staffing patterns for birth centres also vary with some having a separate staff, while others provide the opportunity for all midwives to rotate through the birth centre. In general, most are staffed by small numbers of midwives in order to facilitate continuity of midwifery care. The opportunity to have a single midwife throughout the entire pregnancy and birth however, is not available in birth centres.

In the case of women who do not hold private health insurance, midwives provide the majority of care antenatally with the exception of one or perhaps two visits with a designated birth centre physician. Midwives provide all the care at the time of birth and immediately postpartum with physician consultation provided at their discretion. Women who hold private insurance receive care on a shared basis antenatally with both medical and midwifery involvement. At the time of delivery midwives will provide all the care in labour, however the physicians will be called for the birth and in some cases conduct the delivery. While efforts are made to keep the relationship between the midwife and the physician collegial, the preference for the relative autonomy of the midwives role in the care of women in the public system was expressed by one birth centre midwife as follows:

The mix of public and private patients is sometimes a problem for me..I prefer the care of the public women because I can just get on and do things ..its not that the care really is any different really.. it is just that you have a different mind set at times..that link that there and in the back of your mind you know this is a private case..at the same time I wouldn't want to exclude women with their own doctor from having the care provided by a birth centre, the whole idea is that we want to provide options for women and some wish to have their own doctor..that option should be available rather than excluding it because it limits the autonomy of midwives. (K)

Birth Centres are also available to some independent midwives who have been granted visiting rights, although the numbers of midwives who chose this option over home deliveries has not increased dramatically. The greater availability of birth centres has increased the options for women within the publicly funded system to receive the majority of their care by midwives and has resulted in the opportunity for a small number of midwives to both provide continuity of care and function more autonomously. However, the option is not universally available. The self selection of the clients is well recognized by midwives, many of whom believe that this model of care should be more readily available. Some have suggested that the service is not reaching those who would perhaps benefit most from this form of midwifery care (O'Donnell 1991).

In 1992 there were a total of seven birth centres in NSW. The rapid increase in the availability of this option has been in part a result of the recommendations of the Shearman Report (1989), the availability of funding to the state government through the Alternative Birthing Services program sponsored by the Commonwealth government, and the direct lobbying efforts of women.

7.5.2.5 Team midwifery

The newest form of midwifery practice in a hospital setting is Team Midwifery. This concept of practice had its origins in the Know Your Midwife Scheme (Flint 1987) but it has evolved in a unique way in NSW. In 1991 there were three variations of team midwifery in NSW with two being available within the publicly funded system and the third offered by a team of independent midwives who had visiting rights to a large

teaching hospital. The third form originated in 1984 when for the first time in Australia, midwives were granted visiting rights to the obstetric department of a major teaching hospital in the Hunter Valley in NSW (a rich wine growing and coal producing valley just south of Sydney). This initiative became the model for the accreditation process subsequently developed by the Australian College of Midwives Inc. and later by other hospitals NSW. The concept of a midwifery team evolved into a system in which a small group of midwives offered continuity of midwifery care to their clients throughout pregnancy and birth. Consultation and referral to participating obstetricians is built into the approach. The team midwives based in the Hunter Valley are all self-employed, therefore clients pay them directly for their services and were also responsible for paying the participating obstetricians fees. Clients are largely from the middle class, most held private health insurance and many are from the health and teaching professions (Rowley 1991). The majority were primigravida and were considered to be of low and moderate risk although 21% were high risk. This midwifery team provided care for a total of 559 women from 1985 to 1991 with excellent outcomes (ibid).

A second team project began in 1990 out of the same institution in the Hunter Valley. It again involved a small group of midwives providing total care within a collaborative model with participating physicians. The main difference is that in this case team midwifery is available within the publicly funded system and is part of a research project designed to evaluate the cost and effectiveness of continuity of midwifery care. Designed as a randomised control trial, the project enrolled 720 participants and was completed in November of 1992. Preliminary results indicate that the team functions

well, midwives report an enhanced level of autonomy and a collegial relationship exists with the participating medical staff (Rowley and Saxton 1992).

The third team midwifery project, which began in 1991 in Gosford, is also available to women in the public funded system. The team was selected from the existing staff of the hospital and provides continuity of care to women who are considered to be low risk. This program is relatively new and had some initial problems in establishing support within the medical community, and in providing total coverage on weekends and nights. Reports suggest that the program is now working well and has been well received by the midwives and their clients. A fourth team midwifery project has recently been announced for the Westmead Hospital in the western suburbs of Sydney (Midwifery Matters 1992).

7.6 The independent practice model

Midwives are quick to point out that independent practice refers to a private contractual arrangement between the midwife and her client, but midwives who practise in this way are not independent from the health care system. Implicit in this model of midwifery practice is the concept of autonomy within the recognized scope of practice of the midwife.

Midwives in independent practice are all registered midwives with the exception of a small number of lay midwives. Records of the NSWMA indicate that approximately 40 of their 1200 members are in independent practice. Their influence and public profile are greater than their numbers would suggest.

This model of midwifery practice has been gaining in popularity since the 1970's. The few early practitioners practised alone; however, group practice is increasingly common. Payment for independent midwifery care is on a fee for service basis with fees ranging from A\$700-\$1200. Many independent midwives augment their income from independent practice by working in birth centres or in other midwifery positions.

This model of midwifery care is primarily community based. Many independent midwives have their own offices or provide care in their clients home. Most have arrangements with physicians who provide backup and consultation services. In most cases the midwife will suggest that the client see the backup physician at least once during the pregnancy; however, they are not legally obliged to do so. While a large proportion of births conducted by independent midwives occur in the home, some practitioners who have visiting rights to hospitals or birth centres and can provide this additional option of a birth centre confinement. Some independent midwives only provide services in a birth centre.

The provision of continuity of care and a deep commitment to the right of women to retain control of their childbirth experience are cornerstones of this model of midwifery practice. The practice of independent midwives is not subject to the control of hospital policies and procedure. As a result, each midwife exercises her own professional judgement when making decisions about selection and care of clients, the appropriate place for birth in keeping with the broad standards of practice as set by the ACMI and by knowledge of her personal clinical competence and expertise. Despite the autonomy of practice that is inherent in this model, independent midwives are limited in

the degree to which they can directly access the services of the health care system. Access to laboratory or diagnostic services is only available through a physician and clients of midwives are not able to claim a medicare rebate for their services. With the exception of few private health insurance funds, no monetary reimbursement from private health funds is available to clients of independent midwives. Therefore, access to independent midwifery services is dependant on a woman's ability to pay, effectively eliminating it as a choice for many women in light of the current economic recession in Australia.

Independent midwives in NSW were instrumental in negotiating a contract for liability insurance which has been available since 1991. Prior to that time those practising did so without benefit of liability insurance. The current policy provides liability in the amount of one million dollars. Many area health authorities would prefer that midwives have a higher level of cover, but the NSW Health Department has endorsed this level to be acceptable for the present time (Meppem 1991).

This model of practice provides a great deal of autonomy for the midwife, and offers a high degree of job satisfaction. However, the economic realities of independent practice are such that most midwives must seek additional employment. The numbers of midwives in independent practice have decreased significantly from 1988 to 1992. In 1988 3% of midwives were in independent practice, this declined to 1.8% in 1992 (NSWMA 1992).

The relative isolation that the few midwives in independent practice experienced in the early 1980's is now decreasing as this model of practice increases in acceptance.

The contribution these early practitioners made to the evolution of independent midwifery practice however is frequently acknowledged and valued highly by many of their peers:

I consider those early home birth midwives to be real pioneers, they were isolated by everyone-their peers, the established medical system, even by mainstream Australian society...but they were very strong and courageous..if it had not been for them we wouldn't be where we are today...we owe a lot to them. (L)

7.6.1 Other areas of independent practice

The concept of independent or private practice is not exclusive to midwives who provide primary care to women in childbirth. A small group of midwives have established private practices offering a variety of non-clinical services to women in pregnancy and birth ranging from childbirth education classes, postpartum support and private pregnancy counselling. All such services are on fee for service basis and clients are not eligible for medicare or private health insurance reimbursement. One recent exception is antenatal education provided by midwives which is now being covered by some health plans (Midwifery Matters 1993).

7.7 The Shearman report: implications for midwifery practice

Many of the midwives interviewed for this study considered the Shearman Report to be a landmark document which accelerated the changes in health policy related to midwifery practice that many in the profession had been working towards for many years. The Report clearly recognized the role of the midwife in the care of childbearing women and its recommendations supported the expansion of the role of midwives both within the hospital based system and the integration of independent midwifery practice

with the hospital based services. In addition, it also recognized the right of women to chose the place of birth including the home.

The granting of hospital visiting rights to independently practising midwives was recommended by the Task Force as one strategy to expand the provision of midwifery services and to improve consumer choice. The extension of visiting rights to independent midwives included privileges for normal births in labour wards and birth centres and allowed for a continuing role for the midwife in the care of women who elect to have a home delivery and who require transfer or admission to hospital.

In addition to the granting of visiting rights to independently practising midwives, several recommendation were made regarding the redefinition and expansion of the role of hospital midwives. They included the introduction of an integrated system of community midwives, with privileges in local maternity units. The British "Know your Midwife Scheme" was also suggested as a suitable model for the provision of midwifery care and one which enhanced continuity of care and improved choices for women. The Task force also recommended the expansion of Birth Centre facilities as a means of improving access to natural, family centred childbirth across all hospital settings including specialist obstetric units, smaller district and rural maternity units. Within the Birth Centre model, midwives were identified as primary care givers who would provide care to women though pregnancy, birth and immediately post-partum.

The development of midwives antenatal clinics was also recommended as a means of ameliorating deficiencies in antenatal care as expressed in many submissions received by the Task Force. The dissatisfaction expressed by women included long waiting times

in public clinics, the impersonal nature of care, and in general, highlighted the inadequacy of the current system in meeting the needs of pregnant women in the Aboriginal and multicultural community and those with special needs, such as adolescents.

Other strategies in addition to the expansion of midwifery services antenatally to the multi-cultural community were recommended by the Task Force. Following the release of the report, positions for midwives as Ethnic Obstetric Liaison Officers have been established within the multi-cultural community. These midwives do not provide primary care to women, but rather conduct antenatal classes, support women in labour and provide support and assistance in the postnatal period. They also act as a liaison between the particular cultural group and the health care system. In some cases these midwives have been effective in making hospital services more culturally appropriate (Roumieh 1992).

The Task Force also recommended the expansion of interpreter services for the multicultural community, the development of culturally appropriate antenatal educational materials and finally, the development of continuing education opportunities for health care personnel to increase their awareness and sensitivity to the needs of families from non-English speaking backgrounds.

The Task Force also highlighted the continuing high levels of maternal and infant mortality in Aboriginal communities and noted the need for a review of the existing arrangements for the antenatal care and confinement of Aboriginal women throughout NSW. Current health policy in NSW has determined that Aboriginal women who live

in remote and rural areas of the State are routinely evacuated to larger Base hospitals for confinement. In addition, those who reside in communities where no medical facilities are available must travel long distances for antenatal care. Others received care in their own communities by medical personnel resident in the community or by the Flying Doctor service. Some of the strategies designed to improve the care of Aboriginal women recommended by the Task Force included an expansion of shared care arrangements with maternity units and Aboriginal medical services; the establishment of Aboriginal liaison officers in institutions which serve large Aboriginal populations, more involvement of Aboriginal health workers and community midwives in the provision of antenatal care, improved accommodation for Aboriginal women who are evacuated to base hospital from remote and rural areas for confinement and finally, a greater recognition and involvement of traditional birth attendants. Elsewhere in Australia significant progress has been made re-introducing traditional Aboriginal birth practices and integrating the Grandmothers Law. In Central Australia Aboriginal women have been successful in establishing the Congress Alukura in Alice Springs. The Congress Alukura is a centre where Aboriginal women now receive antenatal care by their own people (and Western midwives). In the near future they will also have the opportunity to give birth in a centre where their traditional birth practices will be honoured and used. At the time of this research no similar progress had been made in NSW.

Several recommendations related to the specific role that midwives could play in improving services to Aboriginal women. The establishment of positions for Aboriginal liaison midwives has occurred in a small number of institutions which provide care to a

large numbers of Aboriginal women. The main role of these midwives is not to provide primary care but to assist in prenatal education, and to improve communication links with community based services such as the Aboriginal Medical Service. Positions for community midwives have also been established in some country areas of the state. They provide antenatal care in Aboriginal communities and have proven to be quite successful (Midwifery Matters 1992). The cultural values and practices of Aboriginal women, particularly the preference for female attendants, is also being acknowledged by the system in general. However, many of midwives interviewed agreed that progress in improving the pregnancy and birth experiences of Aboriginal women has been small and it remains a complex issue which requires action and change on a variety of policy levels.

7.7.1 Implementation of the Shearman report

The Shearman Report was fully endorsed by the Minister of Health and a process for the implementation of its 105 recommendations was established following its release. This process included the establishment of a multi-disciplinary review group which then prioritized the recommendations and suggested actions regarding their implementation. All Areas and Regions were requested to develop Five Year Plans to implement the Report's recommendations and where possible, these plans were to be implemented within current resources. However, enhancement funding was also made available through the State for the development of maternity services until the end of the 1992/1993 year.

In the two year period following the release of the Shearman report the NSW Area Health Services and Regions collectively implemented 80% of its recommendations (NSW Health Department, 1991). Progress on implementing some of the recommendations however, has not been uniform throughout the state. This is particularly true of those which relate to expanding the role of the midwife. Some Health Regions and Areas moved quickly to establish and implement guidelines for the accreditation of independent midwives while others have been slow to provide action on this recommendation. Similarly, the establishment of birth centres have not occurred in all areas of the state despite the desire expressed by women throughout the state to have access to such facilities. In areas where the opposition from the established medical community has been strong, the reforms which involve a more expanded role for the midwife and the establishment of alternative birthing facilities have been slow to develop (Gleeson 1991).

The process of implementing the recommendations intended to improve access and the quality of care for the Aboriginal and multicultural community were also initiated. However, progress in improving this areas of maternity services provision has also been slow and will involve action over a long period of time given the complexity of the many issues involved (ibid).

7.8 Lay midwifery practice

The exact number of lay midwives in NSW is unknown. An estimate provided by ASIM (Lecky-Thompson 1993) indicates that there are approximately five

unregistered midwives practising in NSW. A report by the Complaints Unit, a unit within the NSW Department of Health, which investigated complaints about the health care system, was released in 1991. The report was undertaken after reports concerning unfavourable outcomes of home-births involving lay birth attendants were received. From 1989 to March 1991 the Unit received a total of 10 such complaints mainly from rural areas where communities who have adopted alternate lifestyles such as communal living, are located (NSW Complaints Unit 1991). The complaints originated from hospitals or health care workers rather than the women giving birth or their family and friends. In contrast the complaints received in the same time period concerning births involving doctors or registered midwives totalled 36 and 7 respectively, and originated from the woman involved or her family (ibid).

The conclusions reached in the report indicate that the situation is one that will "surface from time to time but does not require extensive resources of the Complaints unit" (ibid:22). The recent changes made to the Nurses Registration Act make the penalties for the unauthorized practice of midwifery sufficiently harsh to deter most lay midwives from continuing their practice. Recent advertisements for registered midwives to take over the practices of lay midwives appear to support this view (Communique 1992).

While lay birth attendants are offered membership in ASIM and their cause is supported by some of its members, the NSWMA does not consider lay midwives authorized to practise midwifery and is not supportive of appeals for assistance in having

the Nurses Registration Act 1990 amended to recognize the practice of non-registered midwives (Robinson 1992).

7.9 Summary

This examination of midwifery in NSW reveals that significant changes are occurring in the education, practice and the regulatory structure of the profession. New variations in hospital based practice are now providing an opportunity for midwives to function with an increased degree of autonomy. In addition, the concept of independent practice has emerged as a practice option for midwives and is increasing in acceptance within the established health care system. Changes are also occurring in midwifery education. The long history of hospital based training for midwives is about to undergo a significant change as it moves into an academic environment. The interests of midwives are also now represented by two professional associations, the NSWMA and the Australian Society of Independent Midwives. Midwives in NSW are rediscovering their identity as midwives, and are mobilising to reclaim their right to act as primary care givers to women in childbirth. This process has prompted a critical analysis of their relationship with both the professions of medicine and nursing. The changes in the role of the midwife have further been facilitated in part by policy initiatives at both the state and federal level which have recognized the unique role of midwives and the desire of women for more choices in childbirth which include having the choice of midwives as their primary care givers. However, many of midwives interviewed for this study agreed that the profession is far from achieving the level of professional autonomy and ideal role

to which many aspire. What midwives consider to be the barriers and challenges that face the profession as they attempt to achieve these professional goals will be examined in the next chapter.

CHAPTER EIGHT

8.0 Achieving autonomy: a midwifery perspective

As the previous chapter has described, midwifery in NSW is in a period of change. These changes are effecting the infrastructure of the profession, the practice of midwives and the relationship midwives have with the professions of medicine and nursing. Many of these changes have given midwives a greater degree of autonomy and have allowed them to more effectively meet the needs of childbearing women. The purpose of the interviews conducted for this study were to discuss with midwives the changes that have occurred in the profession over time and to examine issues that currently face midwifery. These midwives were also asked to identify the factors that effect the efforts of midwives in NSW to achieve greater independence in their professional practice.

As midwives reflected back upon their practice over the last 10 to 15 years, they described the magnitude of the changes that have occurred in the care of women in childbirth generally and the way in which midwifery practice has changed particularly in the hospital-based system. While these changes have been significant, they fall short of achieving the level of autonomy desired by the leaders of the profession and the choices for care in childbirth that midwives feel should be provided for women in NSW.

The interviews also reveal the complexity of the system in which midwives are now attempting to achieve change. They also provide insight into how midwives view themselves, their colleagues and their place with women in childbirth. The backgrounds

and experiences of these midwives were diverse. However, an analysis of their narratives reveal themes and issues that were common to all despite their differences as midwives. Five major themes emerged from the interviews and were touched upon in some way by almost all of the midwives. These themes are the loss of midwifery skills (LOST SKILLS), the process of how midwives learn and maintain the skills of their profession (RESKILLING), the relationship of midwives to the nursing and medical professions (SHARING THE TERRITORY), issues within the profession itself (BARRIERS FROM WITHIN) and finally, midwifery's relationship with women (BEING "WITH WOMEN").

These themes will be related to the model of professional autonomy previously described in chapter two of this thesis. Within this model, autonomy has two main components which essentially involve the acquisition of control at two levels: at the infrastructure of an occupation (ie. control over the regulatory structure) and control over the labour process. Control over the labour process also involves two main features, authority over the boundaries of job (scope of practice), as well as the work done within those boundaries. Seen in this way, autonomy is a dynamic concept whose main elements are subject to a number of influences. These influences or determinants of autonomy emerge as themes or are contained within the themes brought forward by the midwives interviewed for this study. These themes will be identified and explored in-depth in this chapter.

8.1 Autonomy: different meanings

The concept of autonomy which is central to this study of midwifery in NSW held diverse meaning for midwives. Autonomy was interpreted differently and defined uniquely by many of the midwives interviewed; however, there were recurring elements to the meaning autonomy held for these midwives. As the following excerpts from the interviews will show, these elements related to both aspects of autonomy; occupational control, and control over the labour process.

For many midwives, autonomy meant simply recognition as a professional with a sphere of practice that was unique.

For me it means a literal interpretation of the ICM definition, as a midwife I am recognized as being able to provide primary care within my own scope of practice. (M)

Others pointed out that having professional qualifications and being recognized as having a unique sphere of practice does not always ensure that an occupation has control over how their work is carried out. These midwives further expanded the concept of autonomy as having professional status, a recognized scope of practice and having control over decision making within that sphere of practice:

My qualifications recognise me as a registered midwife-but for me, recognition as a midwife means having control over decision making for the women under my care and having the freedom to consult someone based on my own judgements not on policies or procedure that are dictated by someone else. (J)

For some, an important feature of autonomy also meant the right of a professional to have an equitable degree of access to the larger health care system. This access was critical to the midwives' ability to provide a level of care women both required and desired:

For me autonomy means being able to provide care to women in whatever setting she wishes and fundamental to that is having the freedom to access the system in the same way that physicians do. (M)

While having control over decision making and having an equitable degree of access to the health care system implies a degree of professional independence, most midwives felt that being a part of a larger system of care was also important. For these midwives autonomy of practice still held the responsibility of consulting with other care providers as necessary.

Autonomy means that you are a professional and you make decisions but you are still a member of a team..I mean I am a real team player, even though I am in independent practice I like to feel that I can consult someone and not feel that I have somehow failed or that I have sold out. (K)

No one is really truly independent of the system, not even obstetricians, nor should they be..I mean even they have to consult..the difference is that they control the process whereas midwives don't. (P)

Some felt, that having the freedom to practise autonomously allowed them to use their knowledge and skills fully to meet the needs of women in childbirth. For these midwives the goal of gaining professional autonomy was fundamentally connected to what they felt was their responsibility to childbearing women.

I personally am quite happy with the autonomy I have in my practice but the role I have as a midwife is very different from what the majority of what other midwives have. So, while I feel that we are able to offer some women an optimal level of care, that kind of care is not universally available to all women, particularly those who I feel would most benefit from it..so I guess the goals that I want for all in our profession can't be separated from what I want for women in childbirth. (B)

What are the variables that influence the achievement of the goal of professional autonomy that many in the profession desire? How do midwives view the context in

which they are trying to achieve change? The thoughts and feelings of midwives concerning these issues will be examined in the remainder of this chapter.

8.2 Major themes

8.2.1 Lost skills

Much of the value that is placed on the midwives's role lies in her ability to provide care to women throughout the entire experience of pregnancy, birth and postpartum. Just as the experience of pregnancy is seen as a whole, the role of the midwife is best viewed as a continuous one. Her ability to make decisions is based on her knowledge and understanding of pregnancy in general and is strengthened by a knowledge of an individual woman and her pregnancy. The skills required of the midwife will vary according to the stage of pregnancy, but the knowledge of the past history of a woman and the context of her life enhances the midwives ability to make decisions about her care with confidence and authority. The reality of present day midwifery practice in NSW however, is that with a few exceptions, the opportunity for midwives to provide continuity of care throughout an entire pregnancy and birth has been lost. The midwives role has generally become fragmented and with specialization occurring in one or more areas of pregnancy. The profound effect of this fragmentation and increased specialization on the profession was expressed by many midwives interviewed as they reflected on their own work or as they observed the work of their colleagues. For some, this observation held a sense of loss as expressed by the following midwifery administrator:

..the sad thing is that many of us have lost the ability to see ourselves as midwives, we see our roles as post-natal midwives or labour ward midwives...we have the lost the ability to function in all areas, what you have now is this role that is broken down into parts..we have super labour ward midwives or great intensive care midwives but few who can do it all. (P)

At the heart of this inability to function in all areas of midwifery was the reality that many had lost the ability to use the fundamental skills that would allow them to perform all parts of the midwife's role. The loss of skills can result in an erosion of the confidence that is necessary to carry out the duties associated with those skills. The loss of confidence in turn leads to an avoidance and resistance to attempts that would require that the role be extended once again to all areas of midwifery. These problems were anticipated by some midwifery administrators as they sought to introduce change in their units:

We have thought about rotating our staff but with that you have the need to upgrade the skills that been forgotten or perhaps lost and so we come up against resistance..it is far safer to stay in one area where you feel you have the ability to do the job well. (A)

The loss of skills and a lack of confidence in performing the midwives full role also has implications for the extent to which ownership of a role is felt. Identifying with the concept that the midwives role is a continuous one throughout pregnancy fosters a commitment to preserving the role in its entirety. This feeling of ownership and commitment is important in strengthening a profession's resistance to attempts by others to intrude on their occupational territory. This can be illustrated by the frustration that many expressed about the involvement of other professional groups such as physiotherapy and the most recently, lactation consultants in the care of women in childbirth.

So now we have this new guru, the lactation consultant, who decides how all women should breast feed...we have allowed them to have far too much input..it is the midwife who has the training and the knowledge to provide advice on something as fundamental as breast feeding. (L)

In the minds of many midwives, the combination of the loss of confidence that comes as they become deskilled, combined with the arrival of new experts in the field of maternity care has resulted in a further erosion and devaluing of the role of the midwife. Ironically, some pointed out that the policies and guidelines for these other professional groups are often developed by midwives.

This unwittingly reinforces the idea by midwives that they are not capable of providing total care to women in childbirth:

It is as if we have this mental block or something..I mean on the one hand we embrace the international definition of the midwife but when it comes down to drafting guidelines and regulations we make statements that imply that the midwife isn't capable of making those decisions and that they should call upon the expertise of someone else. (M)

The skills required of a midwife are varied and complex. The evolution in the management of childbirth in Australia has required that midwives learn new skills particularly those related to the use of technology in childbirth. Some midwives suggested that keeping up with the new developments in the management of birth placed pressure on midwives to develop expertise in new and different areas. In some cases, these new skills are those which relate to the use and interpretation of obstetrical technology. These skills are also highly valued in a medical model of care reinforcing the further erosion of midwifery skills in other areas. Those midwives who had been in practice for a long time had the opportunity to observe how the skills required of a midwife had adapted over time and how the value of the "hands on" skills was once

again being recognized. The changing perspective on the value of skills and the emerging sense of professional pride in what some described as revaluing of the "basic skills" of midwifery is evident in the thoughts of a delivery suite midwife whose practice spanned 15 years:

The real art and skill of midwifery at the time was to look after all the monitors and to get the obstetrician there on time..not even to get a normal delivery just to orchestrate it so that it might even be convenient for him to put on the forceps..I considered it to be a real honour to be working at a large teaching hospital in Sydney because I came from the bush, I mean I had friends that were out there doing it all without all the technology but I thought I was doing real midwifery....it has changed now, I mean there is a real pride in helping someone get a normal delivery and do to it with out the bells and whistles..(U).

However, the work of midwives within the hospital system remains complex and even though the degree of intervention in birth may have decreased, some midwives still expressed the feeling that the skill in tending the machines had been replaced by other requirements of the job. These included time consuming tasks associated with record keeping, organizing aspects of care and communicating with others who may be involved in a woman's care. In some cases this seemingly complex structure created for the provision of care particularly in large maternity institutions, prevented midwives from being at the side of women as they laboured and using their basic midwifery skills. This view was expressed by an independent midwife who in the course of doing research, had the opportunity to observe the work of her colleagues in hospital based practice:

I really noticed it when I did the project, I mean it was the student midwives who were looking after the women, the registered midwives were either doing the paperwork or were on the phone calling doctors and ordering tests. (C)

The impact of the loss of skills and its implications for the profession were profoundly felt by many midwives. Some practising midwives described their efforts to regain these skills and the joy they felt at feeling they had rediscovered midwifery. Others who were not currently in practice shared with me their feelings of how important it was for midwives to regain the fundamental skills of midwifery and how best to achieve that goal.

8.2.2 Reskilling

The educational system of any profession acts as a vehicle for the socialization of newcomers to the profession and provides the foundation from which knowledge is transmitted and skills are learned. This educational system must also prepare the student to function competently, and equip practitioners to work within the reality of the work environment. Given these broad objectives, and the current goals of the profession, it is not surprising that many midwives felt that the present educational system was in need of fundamental change. This system, whose roots lay in a hospital-based model of education and which included a commitment to meeting the service needs of institutions needed changes in order to prepare midwives of the future. These changes involved the process and context in which the basic skills of midwifery are learned and what some described as the "basic socialization" of the midwife.

Most midwives agreed that "hands on" skills lay at the heart of the profession and that those skills must be preserved within any educational program. It was these basic skills that many felt were vital to the midwives' ability to function competently across

all settings. Some midwives, particularly those who chose to enter into independent practice, felt their education did not prepare them with some of the basic skills that were so essential to them as practitioners:

The basic form of education I feel has fallen short of it's objectives. We had to learn a lot of really fundamental things ourselves, like ordering tests-which ones were appropriate and which ones were not. Right down to what was the best way to provide antenatal care, based on holistic principles not the five minute encounter. (C)

Most midwives who chose independent practice turned to an apprenticeship model in order to learn the skills that they felt were essential to their ability to function as independent practitioners. For most, this involved a variable period of apprenticeship with another independent midwife. Here they developed the ability to perfect the skills they had been exposed to as student midwives and to develop others that became essential to them as practitioners. One midwife, who recently qualified, described her feelings upon receiving her midwifery qualification as acquiring not a license to practise but "a license to learn midwifery". This midwife went on to apprentice with an independent midwife before establishing her own practice. Midwifery has a long tradition of passing on skills from one practitioner to another. The value of expert practitioners in the transmission of midwifery skills was expressed by many midwives as they described experiences that highlighted or influenced the way they developed their own clinical skills. These "experts" appeared to exist across all practice settings and had a lasting effect on those midwives who learned from them:

I worked mainly nights as a student and at the time there were a group of Scottish trained midwives on the labour floor who really had a hands off policy..they didn't rupture membranes or do routine pelvic exams to assess progress in labour, I learned the value of listening and watching women in labour..those skills have stayed with me and are really useful to me now wherever I practice. (M)

It is the preservation of the input that these practitioners have to the educational process that many considered to be one of the key elements that would better prepare midwives to develop the skills that would form the basis of their ability to practise autonomously. Some expressed concern that with the increasing value placed in academic qualification for teachers of midwifery could jeopardise the role of expert clinicians many of whom did not have academic qualifications.

The environment in which skills are passed on is also a key factor in the development of the midwife. In many ways it determines what skills are learned, which ones become valued, and the degree to which confidence as a professional is developed. The complex structure of a hospital environment which provides the structure for the work of the midwives poses a challenge to process of education. The pervasive influence of the medical model of childbirth, the lack of opportunities to learn the principles of continuity of care and finally, a system which in many cases discourages the development of confidence and independence, were all recurring elements which characterised many of the interviews. These elements are well expressed by two midwives, a former clinical educator and an independent midwife:

The hospital environment is pretty limited as a place of learning..you have fragmented care and a system which doesn't really encourage you to see the broader issues..you can teach it in all in theory but the reality of the hospital is that it is very rigid-it makes you focus on the tasks. (R)

There was always this focus on the abnormal, this overwhelming sense of- what if something happens..as a student that really effects the way you view things..the teachers made a really good effort at creating the view that pregnancy was normal but their was always this fear of something going wrong-you could almost feel it..I felt I turned a corner professionally when I didn't fear birth any more but it took me a long time. (J)

In addition, some expressed the view that the exclusive use of the model of hospital based maternity care on the education of midwives further increased a reliance on technology and weakened the ability of the midwife to have confidence in her skills outside of a hospital environment.

Despite the criticisms that were expressed about the hospital-based model of education, many midwives viewed the move to a university model with mixed feelings. While on the one hand they realised that in order to achieve their professional goals a change in the educational system was necessary, alternatively some had suspicions that a university-based model would further erode the acquisition of the "practical" aspects of midwifery. These concerns appeared to originate from the experience of the university based nursing programs that produced graduates who were "all theory" and not able to function adequately in a clinical environment upon graduation. Whether it was the preservation of the hands on component of midwifery education that most felt was in danger of being lost, or the anxiety that is created when change is about to occur that caused some midwives to express this concern, is unclear.

The anxiety expressed by some regarding the changes in midwifery education appeared to be offset with a sense of renewed hope. The danger of losing some skills was balanced with the anticipation that university education would result in the acquisition of skills in the area of research, problem solving and more importantly, that

learning would take place in an environment that would foster the development of confident and assertive midwives. These skills were considered to be essential to prepare future practitioners as one educator and independent midwife suggest:

The midwife of the future will be totally different than the midwife of the past, some will say this isn't good but we have to change..when we trained in the hospital the goal was to adapt to what was happening in the unit and to what the doctors were doing and accepting that without question. (T)

There are pluses and minuses...I think a tertiary based program will prepare them to stand up for themselves, to have more confidence in their ability to question things and being able to do research is a plus..However, I am concerned that they will be removed from being with women and from the midwives who are really skilled. (C)

Finally, the move into the tertiary sector will bring the education of midwifery more closely aligned with that of nursing. Midwifery education will still follow the acquisition of nursing education but it will no longer have the distinctness of being in a separate school. Rather, it will become a specialty stream within larger nursing departments. The implication of this weighed heavily on some midwives who considered this to be a critical factor in the degree to which midwives would be able to develop their own identity, distinct from nursing. In addition, some felt that the common core of midwifery and nursing would interfere with a process of socialization which would form the basis of being able to assume a primary care role. These concerns were well expressed by one midwifery educator:

I think there is great potential to improve the profession by elongating the education but in midwifery NOT nursing..we need to develop our own research base and that won't happen in the present system. The only way to achieve it is if from day one of the educational program the student is socialised into being a midwife, an autonomous care giver, then they will have a better chance. Every one of the students I have comes to me first as nurse and five months down the track they are still thinking like nurses. (M)

However, this view was not universally shared, although most midwives could accept the validity of the argument, many felt that the reality of midwifery practice in many cases required that the practitioner possess both midwifery and nursing skills:

It is a conflict for me, I happen to think that if midwives are going to meet the needs of all women and be able to work in places were they are really needed like in the bush they are going to have to have to be all-rounders which means having some nursing skills..so I guess that we need to retain it for that reason but then get on with it. (F)

This debate will continue as midwives examine their troubled affiliation with nursing and attempt to redefine their relationship with medicine.

8.2.3 Sharing the territory

When one considers the development of midwifery in Australia and its historical relationship with medicine, it was not surprising to find that the importance of re-negotiating that relationship emerged as a dominant theme. Unlike Canada and the United States where the medical profession was almost successful in eliminating a role for the midwife, Australian midwifery survived such efforts. Nevertheless, like many other Western countries, the role of the physician in childbirth in Australia remains a dominant one. In NSW, physicians have retained their control over the care of women in childbirth and to a large degree over the work of midwives. Although midwives and physicians work closely together, some midwives observed that their medical colleagues did not regard them with the same level of respect that they perceived other midwives, for example those in Britain, are afforded by their medical colleagues.

The prevailing view among physicians that midwives are assistants to physicians originates in the socialization of physicians and is reinforced by the existing models of care in which physician and midwives work together. The relative lack of a collegial basis for this relationship was observed by some:

It is really interesting to see how they relate to midwives after they came back from England after their exams..there they had seen a system where midwives are treated with respect..it has an influence for a while but usually it isn't long before the old boys get them in line. (L)

There is some indication that physicians' attitudes towards midwives, as well as their degree of control over midwifery practice is changing, as midwives become more successful in establishing new variations in practice in which they assume a more autonomous role. As these new practice models emerge, they serve as an example which influences how students of obstetrics view the relationship between midwives and physicians. Evidence of the changing nature of this relationship was apparent in many of the interviews as midwives spoke of both their past and present working relationship with physicians:

Back in 1976 it was a real "us and them" situation, we were very subordinate, very oppressed....the whole practice of midwifery at the time was dictated by hospital policy with the backing of the VMO..now it is much different, we have a lot of autonomy in the management of the normal labour, we are viewed more as colleagues and decisions about care in labour have to go through the midwife. (H)

However, the change in the relationship did not happen quickly and early attempts by the few midwives who sought changes and who approached physicians to provide backup for them as they entered into independent practice, were often characterised by a patronising attitude and a measure of disbelief:

They were just so stunned at the effrontery of us-they couldn't believe it..I'm sure they thought it was just a flash in the pan and that it would soon die off but we didn't, we are still here. (T)

Many midwives indicated that physicians appeared to give a measure of acceptance to the changes in the midwife's role in hospital, but the development of independent midwifery practice was opposed by the conservative elements of the medical profession who were in the majority. Enough support from key individuals within the medical profession was available however, so that the growth of independent midwifery and other variations of more autonomous practice have continued.

The control that medicine exercises over childbirth and the degree to which midwives remain dependant on the support of physicians in their own attempts to regain professional autonomy emerged as a strong element from many interviews. But the nature of that dependant relationship may be changing as midwives rethink the advantage their central role in childbirth may now give them:

It is interesting to watch, when they (doctors) first set up in practice they want to do what women want and to be seen as progressive so they may work with us and in turn we become a source of referrals. (S)

We had a very supportive head of obstetrics at the time when things really began to change and he was not unaware that the statistics were showing that we had really high rates of intervention which is a reflection on physicians' practice..so I guess he felt that if you give a little more to the person at the bedside then it could be turned around to make them look better. (P)

The potential inter-dependant role of the midwife and the physician may now form the basis from which a new collegial relationship will be established. Strong opposition remains within the medical profession however, and the support for more autonomy for midwives remains scattered. The importance of building on the minority of those who

are supportive appeared to be critical to many midwives, as suggested by the thoughts of this highly respected independent midwife:

You don't need all of them to support us..what we have managed to accomplish here is a result of building on the support of a few..in the beginning we had to prove ourselves but now we have established our credibility and it works..for all of us. (P)

The influence of past ways of interacting and the historical relationship between midwives and physicians have shaped the manner in which most midwives and physicians view each other. Successful re-negotiating of a new relationship will in part be determined by the degree to which both are able to reinterpret their view of each other and develop a measure of trust:

A lot of them know me because I was a labour floor midwife so they know the skills I have...that influences the way they see me even now that I am in independent practice. (K)

I have a lot of respect for the person who acts as back up for me..I don't see him as having the need to exert his power over me and so I trust that he will respect our relationship and trust my judgement. (J)

The appearance of an evolving relationship in which the care of women in childbirth is more equitably shared may however, be an illusion and not evidence of a fundamental change in the degree to which physicians are willing to relinquish their control of childbirth. By supporting new models of care that appear to give midwives more autonomy, the medical profession is seen to progressive and supportive. However, the medical profession continues to retain the power both of giving such "rights" and taking them away. Allowing midwives to regain real autonomy would involve relinquishing control over the mechanisms that would allow midwives to access to health care funds and health care services, on an equitable basis:

Nothing much has changed in the system yet that would prevent physicians from taking back that role if they wished..viewed in a relative sense we have made enormous gains but that fundamental control over access still is held by doctors. (L)

Many however, accepted the reality of their relationship with physicians and expressed a desire to continue their efforts at re-negotiating the basis of that relationship, a task which some characterised as a "consistent effort" and others a "hard fight".

The most consistent reaction that we got from the physicians here was bemused indifference, but we are lucky, elsewhere the changes have been met by real overt hostility, the pompous ones can't wait for midwives to have problems so they can resume their autocratic stance. (A)

The emergence of a desire to become more autonomous and to reclaim a primary care role for women in childbirth appeared to be the stimulus which caused many midwives to reexamine their relationship with nursing.

Like medicine, the issue was one of control, but not of the territory of childbirth, but control over the decision making process related to the fundamental basis of the profession including the regulatory structure, education and practice. Many of the midwives interviewed appeared to be developing a resistance to further incorporation into nursing which some felt would further result in a loss of identity for midwives. Some midwives suggested that the historical relationship between the two groups appeared to be satisfactory and until recently was accepted without question by most.

As a result of the growth of specialization in nursing the distinctiveness of midwifery appeared in danger of being lost. Being seen as something other than just another specialty within nursing emerged as an important issue for many midwives. As previously discussed, with career advancement in nursing now being possible through

other specialties, the traditional assurance that senior policy makers would in all likelihood be midwives could no longer be assured. The implication for many was that the control of decision-making on issues related to midwifery would now be vested in the hands of nurses who could not be expected to adequately represent the interests of midwives:

Midwives need to make decisions for midwives, we cannot expect nurses to do it for us, they don't understand what the issues are because they are not midwives, it is as simple as that... (H)

Having control over the early socialization of those in the profession also appeared to be a critical variable in determining the extent to which midwives could develop an identity as primary care giver. For some, the prior socialization in nursing represented a significant barrier to development of an identity as a midwife who was capable of assuming an autonomous role. Central to this view was an examination of what many saw as the nature of the differences in the work of midwives and nurses, as well as the increasing tendency of midwives to critically examine the relevance of the medical model of childbirth:

Although there are exceptions, nurses generally carry out the orders of physicians and they care for ill people..midwives on the other hand have the ability to make a diagnosis and carry out a plan of care without physician involvement and we care for women who are well not ill. (E)

The differences in approach and orientation between nursing and midwifery was also revealed in the tendency of nurses to look to midwives as they develop their own strategies for developing more opportunities for autonomous practice. As one senior nursing administrator observed:

There is no question that midwives have led the way in the development of new nursing roles in Australia..we have a lot to learn from them, there is no question that nurses in general have lagged far behind midwives. (O)

The inclination to view midwifery as separate from nursing and the desire to establish a separate structure for the profession was however, not universally shared. While some midwives acknowledged the need to have more control over decision-making, they were disinclined to see the advantage of further distancing themselves from nursing and acknowledged the advantage that midwives held because of their access to the strength in numbers of the nursing profession.

While conflict in the relationship between nurses and midwives emerged as a dominant theme in these interviews, it is difficult to know how widespread the support for the development of midwifery as separate from nursing is among the profession as a whole. However, it does appear to be a view that is strongly held by the leaders of the profession and other midwives who are very active in the development of a more autonomous role for midwives.

8.2.4 Barriers from within

The changes that have characterised the role of the midwife in NSW have not only caused midwives to reflect on their relationship with physicians and nurses but have resulted in a critical examination of factors within the profession which influence the future development of the profession.

This process of self-examination revealed a need for fundamental changes in the way midwives both view themselves and their role in childbirth. As some suggested, the

development of more autonomy for midwives will result from changes to the system that allow midwives greater flexibility and autonomy, but will also depend on the extent to which midwives are willing to accept the responsibility that accompanies such change. Many argued that lost skills, a lack of confidence and a system which imposes strict controls on practice, has produced midwives who are find change difficult and threatening:

When I came here the role of the hospital midwife could only be characterised as being oppressed and repressed, it was very difficult to introduce change in a system where midwives had previously been sanctioned for stepping out of the boundaries. (P)

The predictable nature of their work and the relative safety that comes from a system which clearly defines the limits of decision-making has produced many midwives who are resistant to change and prefer instead to accept the status quo. The barriers that exist within the profession itself emerged as a strong theme as many midwives frankly assessed the factors within their profession that constrained the further development of autonomous practice:

Midwives can be their own worst enemies at times, we sometimes have a hard time seeing ourselves as midwives, we resist change, and we get really distanced from each other. (M)

The support of a peer group and the strength that comes from knowing that you have acceptance and understanding from others in your profession is also an element which influences the extent to which many are willing to challenge the system and to establish a foundation for future change. As many reflected on the early experiences of those who sought changes to the role of midwife, it was clear that in the beginning, the

majority of midwives did not understand the need for change and did not provide support to those who had the courage to defy the system:

I wouldn't exactly call it a witch-hunt but the opposition to home birth and to independent practice was very intense among midwives in the early days..we faced tremendous criticism from our peers it was often highlighted when we had to transfer someone in..I'll never forget how I felt when another midwife wrote "failed home birth by Sister B." on the front of someone notes. (K)

As the changes to midwifery practice have evolved, so too has the degree of acceptance that midwives have of each other. The feeling of isolation and loneliness which characterized the experience of those midwives who were among the first to enter into independent practice appears to have changed as one midwife observed:

I remember how lonely I felt when I brought someone in...and I'd spend the whole time alone with a women in labour..it took time for them to accept me..I had to prove myself in a way..it was so wonderful when someone appeared to give me a hand or relieve me for a cup of tea. (R)

Strengthening the bonds of trust and creating solidarity among midwives appeared to be an element that many considered was crucial to ensuring that the energy of midwives was directed at facilitating change rather than fuelling discord within the profession. However, given the diverse nature of midwifery practice and the wide interests of midwives, many realised what a difficult task it is to create such a balance:

We have so many different types of people..you have the plodders which some consider me to be, then there are the enthusiastic ones who really want to get on with it and then there are the way out ones who really feel the rest are so conservative.and then of course there are those who are really apathetic. (L)

In addition, the development of a sense of collective strength and pride as midwives can be undermined by the development of a attitudes which foster the view that some midwives are considered to be practising are "real" midwifery, while the practice

of others falls short of ideal midwifery practice. Again, despite their differences as midwives many expressed a strong desire to minimise what many considered to be the development of divisive forces within the profession:

We are all in this together, we are all midwives and we should respect each other as colleagues..I mean who is the College?..We are the College and we should not critical of a process that we have done nothing to try and change. (K)

Finally, existing in a system in which you have been controlled by others, and which has fostered the development of dependence and a lack of confidence has caused many midwives to underestimate the extent of their strength and power:

We should never underestimate the degree of power that we have as midwives and we should develop natural alliances that foster us regaining what is rightfully ours. (P)

8.2.5 Being with women

The evolution of the care of women in childbirth in Australia, like many other Western countries, resulted in the displacement of the midwife from a central role as a provider of primary care in pregnancy and birth. The rise of medical dominance in childbirth and the structures that were created for the provision of maternity care, facilitated a fragmentation in the role of the midwife and created what some midwives considered to be a growing distance between midwives and women. The height of this distance occurred in the 1970's when rates of intervention in childbirth were high, home birth had virtually disappeared, and alternatives to the strict policies of institutional birth were few. As some midwives noted, the movement for change in the management of childbirth was initiated not by midwives but by women, their families and other supportive groups such as childbirth educators. For some midwives, womens'

dissatisfaction with the existing system provided a catalyst that caused them to re-examine their work and ultimately their relationship with women. This critical examination led to the realization that they had to stop and listen to women. This view is well expressed by one long time clinical midwifery educator:

I remember when I was a student and the women used to say "But I could push better if I could just sit up-or I'll be able to breastfeed once I go home when there isn't this routine...then I started reading some of the early books like Suzanne's Arms and I realized that it wasn't just a few women who were saying that..I think it reinforced what I intuitively felt but wasn't able to do because of the system.
(M)

The highly regulated nature of hospital-based care and the pressure to function in a system which did not always coincide with the real needs of childbearing women, created conflict for many. As some midwives noted, this conflict led midwives to have divided loyalties, one to the employer and one to women. The result was that for a time it was difficult for midwives to meet the needs of both. The temporary loss of a central goal of midwifery care-to act as an advocate for women-was articulated by one senior midwifery administrator:

The practice of hospital based midwifery became extraordinarily regulated and I think midwives forgot their role as advocates for women. We have gone through so many trends, for a time everyone had an episiotomy or an epidural and midwives went along with it, for a time. But then we began to acknowledge the fact that women and their families have rights and should have a choice and be involved in decision making..that has really influenced the evolution of practice.
(A)

There is little question that midwifery practice has evolved over time and is now more centred on the needs of women. These changes have coincided with a general process of change in childbirth practices combined with policy changes in the system which now enable midwives to assume an advocacy role for women and function with

greater autonomy. Many of the midwives interviewed expressed the view that in returning to a role as advocates for women the profession had re-established a positive public image. However, they had not yet established themselves in a role as legitimate primary care givers in the eyes of women. As a result, many suggested that one of the major goals of the profession was to re-educate the public about the role of the midwife. In addition, some also felt that it was necessary to separate the issue of midwifery from the emotional debate that often surrounds issues related to the place of birth. These complex issues are expressed by the following birth centre midwife:

We have to educate the public, and the consumers of childbirth services about the role of the midwife and what we are able to provide, as well as reinforcing that birth is normal and it isn't necessary to have a physician look after them if they are having a straight forward pregnancy. Consumers get frightened-we get a lot of negative press arising out of home birth and some of those who don't support midwives use it against us. (K)

The task of re-educating the public was considered a difficult task in light of the fact that Australian women have come to expect that care in childbirth should be provided by physicians. This combined with the prevailing medical model of birth represents a challenge for midwives:

If you actually canvassed the Australian public they would probably say you couldn't have a baby without a doctor there just in case something went wrong. But they don't see the doctor as just being there for backup, it is normal procedure to seek out a doctor when you are pregnant. What they don't see is that what they are getting for their money is a lot of over servicing and intervention. (C)

Some midwives expressed frustration at having to disprove the prevailing view that midwifery care is somehow second best when compared to the gold standard of physician care. This need to prove oneself, in addition to explaining the role of the

midwife over and over again is described by one midwife as she recounted her feelings when she first began to see women as part of a shared care arrangement with a consultant obstetrician:

It was a bit funny at first because I would do the whole antenatal check as he would and then I would do all my teaching and I was really aware that they were paying to see a doctor and they might be disappointed at seeing a midwife so I ask them at the end if they want to see him even though there is no need..I find I spend a lot of time explaining what a midwife can do, a lot of them just aren't aware. (P)

In addition, given the changes that have occurred in the management of childbirth in Australia in the last 20 years, the current choices that are available may represent enough change to be satisfactory for many women so that they do not feel the need to actively seek alternatives such as primary care by a midwife. As one independent midwife pointed out when it came to childbirth, women have lost the "fighting power of the oppressed" and as a result are less likely to seek the care of midwife, particularly when they must often pay directly for this service.

Finally, for some midwives the key to increasing the collective autonomy of the profession lay in the success of models of care such as Team Midwifery which facilitated the continuous relationship with midwives and women. This model provides the greatest potential for proving the value and effectiveness of midwifery care as well as upholding the principles of continuity of care and accessibility:

A lot of what has happened in the past few years has had the appearance of change, and of giving control back to midwives. But all the policy changes have stopped short of giving midwives real power that comes with being able to be provide continuous care and allow us to prove our value within the system and to women. If we are able to practise in the system the way we should, as midwives, then I think we will have enough support from women that having access to primary care by midwives will become a political issue. (P)

8.3 Discussion

How do the themes of LOST SKILLS, RESKILLING, SHARING THE TERRITORY, BARRIERS FROM WITHIN, and BEING WITH WOMEN relate to the concept of autonomy as presented in this thesis?

LOST SKILLS

The theme of LOST SKILLS clearly articulates midwives concern over how the evolution in the care of childbirth in Australia has resulted in the fragmentation in the role of the midwife. The consequences of this fragmentation, and the subsequent specialization in one aspect of midwifery, for many midwives has resulted in the loss of the entire spectrum of midwifery skills. This has lessened midwives' ability to function in accordance with a recognized scope of practice. Within this scope of practice, the ability of the midwife to provide care to women throughout pregnancy is implicit. Therefore in order maintain legitimate claim to this sphere of practice, the midwife should in fact possess the skills and expertise to provide care within that sphere.

The loss of professional confidence that comes when skills are lost, combined with a loss of authority as a role becomes devalued, both contribute to a weakening of professional boundaries as well as influencing an occupation's ability to do the job in accordance with that scope of practice. This overall weakening of an occupational role facilitates the intrusion of other occupational groups into it's sphere of practice. Changes to the NSW Nurses Registration Act which allow nurses without midwifery training to provide components of midwifery care is one example of midwives' vulnerability to

maintaining a claim to a unique sphere of practice, as well as their inability to control the intrusion of another occupational group, in this case nursing.

RESKILLING

Equally important as the loss of skill is the challenge of RE-SKILLING midwives with the skills that are considered necessary for maintaining the ability to make independent decisions within their recognized scope of practice. As many midwives pointed out, the non-technical "hands-on" skills of the midwife, are ones that must be preserved and strengthened in order to foster confident and competent midwives who are able to work across all settings. Learning the skills of midwifery exclusively in a hospital environment where it was possible to defer decisions to someone else, and with the availability of obstetrical technology, posed limitations on the extent to which the midwife could develop sound skills which form the basis for independent decision-making. In addition, the hospital environment not only subjects the work of midwives to institutional control but it also determines which skills are learned and how that knowledge is transmitted. Despite efforts by midwifery educators to present alternatives, the strength of the medical model of childbirth and the degree of bureaucratic control over the work of midwives exerts a profound influence on the socialization of students of midwifery. As many midwives pointed out, the importance of learning midwifery in a variety of settings, and in particular settings where midwives provide continuity of care and practise more in keeping with their legally recognized scope of practice appeared to be critical to the development of future midwives. As more such practice models

emerge, both in the hospital model (ie. Team Midwifery, Birth Centre), and as the acceptance of independent practice grows, these opportunities will become more readily available.

What also emerged from the interviews was the importance for midwifery of acquiring additional skills, such as those of conducting research. Some of the midwives interviewed suggested that these skills could prove critical for midwives as they sought to demonstrate that increased professional autonomy was not detrimental to mothers and babies, but in fact could result in more positive birth experiences for women, improved birth outcomes and (hopefully) less cost to the health care system.

In addition to these influences some midwives felt that grounding midwifery education in nursing hampered the development of a professional identity in which responsibility for independent decision forms the basis for practice. This issue was further developed within the theme of SHARING THE TERRITORY.

SHARING THE TERRITORY

Within this theme, the complex relationship that midwifery has with both nursing and medicine emerged. In the case of nursing, this study indicated that midwives were beginning to resist the degree of occupational control that nursing has historically held over midwives in NSW. This authority was apparent both at the level of occupational control and control over the labour process. The re-emergence of a separate and distinct identity for some midwives in this study was indicative of efforts to achieve greater autonomy through the preservation of distinct occupational status and recognition within

the regulatory structure of nursing. Some midwives in fact suggested, that the first step in achieving greater autonomy was to lobby for a separate Midwives Act which would give midwives distinct occupational recognition and secure control over the regulatory structure of the profession.

Midwives also appeared to be resisting the degree of control nurses had over the work of midwives. Some midwives in this study maintained that because the nature of the work differed between the two, nurses could not adequately represent the interests of midwives nor make decisions which related to the work of midwives. The debate over the changes to the Nurses Registration Act appeared to demonstrate for midwives, that nurses could not adequately understand the nature or importance of midwife's work. Therefore it was inappropriate for nurses to assume the responsibility for making decisions that would effect midwifery practice. In addition, with increasing specialization in other areas of nursing many midwives pointed out that the traditional assurance that nurses in leadership roles would also hold midwifery qualifications could no longer be guaranteed. Therefore it was imperative that the control over the decision-making process as it related to midwifery practice be held by registered midwives. Many noted the irony, that as nurses sought to gain more autonomy from medicine, it was midwives to whom they looked for assistance in developing models for more independent practice. Finally, the close alliance of midwifery and nursing was regarded by some midwives as an obstacle to the negotiation of more autonomy vis a vis medicine, due to the overall subordinate status of nursing to medicine.

Like many other features of midwifery in NSW, this study suggests that the relationship between midwives and physicians appears to be changing. Challenges by women to the supremacy of medicine over many aspects of care in childbirth have resulted in changes in the way birth is managed in Australia and have lessened the degree of control that physicians exert over the management of childbirth. In many cases, this challenge to the medical model of childbirth, has resulted in midwives assuming greater control over decision making and greater opportunity to function independently. However, as many midwives pointed out, the achievement of greater autonomy for midwives is still very tied to the support of physicians. The success of new hospital based models of practice such as Team Midwifery, and Birth Centre practice remain dependant on the availability of physicians who are willing to act as consultants to midwives. Similarly, midwives in independent practice who wish to offer their clients the choice of birth in hospital are dependant on a system (which is largely controlled by physicians) to grant them access, in the form of visiting rights, to the larger hospital system. Even midwives in independent practice, who appear to have the greatest degree of control over their work, remain dependant on physicians who act as gatekeepers to the health care system and who will perform functions such as ordering routine tests and diagnostic procedures if required. Finally, the impact of the Ministerial Task Force on Maternity Services in NSW and the support of it's chairman, Professor Shearman, in initiating policy changes related to midwifery practice cannot be under-estimated. Many of the midwives interviewed suggested that while the specifics of recommendations were not new, especially to many midwives who had been working toward change within the

system, the fact that they were made by the Task Force and supported by its chairman increased the likelihood that they would be acted upon by policy makers. Building on the support of key physicians appeared critical to the further evolution of practice relationships between physicians and midwives in which midwives assumed greater control over both the boundaries of the job and the nature of the work within those boundaries.

BARRIERS FROM WITHIN

In this theme midwives spoke of the issues within midwifery itself that influenced the attainment of greater professional autonomy. Clearly, this goal involved change both at the level of occupational control and at the labour process level. This goal is one that cannot be imposed on an occupational group by its leaders, but must be desired by the majority in order to become a reality. While many of the midwifery leaders in NSW appeared to desire greater occupational recognition and even the power to become self regulating, one cannot assume that this is a goal that would be supported by the majority of midwives in NSW. Although changes in midwifery practice which have given midwives more responsibility and control over decision-making have been welcomed by many, these changes have at times also been met with resistance by some and have not been embraced by all midwives. With increased independence comes greater responsibility for making decisions. Given the recent history of midwifery practice (ie. 1970-1990) where the role of the midwife had become increasingly fragmented and the parameters of decision-making were defined by institutional policy, it is not surprising

that some would approach the opportunity to practise with more autonomy with uncertainty. While individual midwives may not wish for more independence in their own practice, it is an overall professional goal that is worthy of their support so that midwives in the future will have the opportunity to have a greater degree of autonomy in their practice.

BEING "WITH WOMEN"

The emergence of what some midwives described as their "midwifery identity" has fostered a return to what some considered are the basic goals of midwifery. These essentially are to act as advocates for women and preserve birth as a normal human experience. However, in order to achieve these goals and effectively "Be with Women" midwives must have control over both the infrastructure of the profession, as well as the decision-making process regarding midwifery practice. For midwives then, the importance of achieving greater autonomy is not attainment of professional power and control in and of itself, but as means by which the birth process can be de-medicalized and the control of childbirth returned to women. In order to achieve this goal however, midwives and women must become allies in the process. Ironically however, midwives must first re-establish the legitimacy of their role in the eyes of women, and dispel the view that midwifery care is somehow second best when compared to that provided by physicians. In short, they must create a demand for their services that will be heard by policy makers. An increase in the accessibility of variations in practice models where midwives are able to provide continuity of care, and remain relatively free of medical

and bureaucratic controls within the publicly funded health care system, will enhance the midwives ability to generate the support of women. This in turn may serve to enhance the argument for greater access to public funds and the services of the health care system by more midwives including those in independent practice.

In conclusion, these interviews with midwives indicate that despite a progressive loss of autonomy in recent years, the role of the midwife in NSW appears to be changing. Midwives are beginning to seek greater control over the decision-making process which effects the education of midwives, the regulatory basis of midwifery and finally, midwifery practice. New practice models are now becoming established which offer the opportunity for midwives to practise with a greater degree of autonomy as well as providing an alternative to a physician-centred model of care. However, as many of the midwives in this study suggested, these recent changes fall short of ensuring that midwives acting in a primary care role are accessible to all women who desire such care. The interviews conducted for this case study reflect the complexity of the system in which midwives are now attempting to achieve further change. While some of the issues are specific to the context of midwifery in NSW, many relate to the experience of midwives in other jurisdictions. The implications of the findings of this study and their relevance to the development of midwifery in Canada will be explored in the concluding chapter of this thesis.

CHAPTER NINE

9.0 Summary and conclusions

The purpose of this project was to conduct a study of midwifery in Australia. The degree of midwives' professional autonomy and the professions' perceptions of the factors which influence this level of autonomy, was the central question the study sought to examine. The state of NSW was chosen as the site for the study, and the research was conducted during a six month period, from July to December 1991.

A conceptual framework for the study was derived from an approach developed by Coburn (1988). This approach suggests that professional autonomy involves control by an occupational group at two levels; the regulatory level and at the labour process level (the actual work of the occupational group). Control at both levels is subject to a number of influences.

Utilizing a case study method, information on the regulatory structure, education and the practice of midwives was collected. The principle sources of data included: documents and archival records, interviews, site visits and observations at meetings and midwifery conferences. In order to more extensively examine issues related to the autonomy of midwives, in-depth interviews were conducted with 38 midwives. These midwives were selected from the areas of education, practice and administration.

The results of this study indicate that midwifery in NSW is undergoing a period of significant change. Changes are occurring in three main areas of the profession: its regulatory structure, education and practice.

Midwifery in NSW is included within the regulatory structure of nursing. Changes to the Nurses Registration Act in NSW over a period of time have resulted in the erosion of the distinctness of midwifery within the regulatory structure of nursing and a diminished opportunity for midwives to have direct input into decisions that effect their practice at the regulatory level. In addition, the most recent changes to the Nurses Registration Act permit nurses without midwifery training to practise midwifery under certain conditions. These recent changes suggest that the traditional occupational territory of the midwife, -the care of women in childbirth-is vulnerable to the intrusion of another occupational group, nursing. In response to these changes, some midwives are beginning to actively resist the degree of control nursing has over their practice at the regulatory level. This has been facilitated by strong leadership provided by their professional association, the NSWMA, and the emergence of what some midwives described as their "midwifery identity".

Changes are also occurring in midwifery education. The long history of hospital based education is ending and is being replaced by educational programs located within nursing departments at the university level. This change, while supported in general by the profession, remains a source of concern for many.

Some fear the loss of the opportunity to learn and perfect the non-technical skills of midwifery, a greater emphasis on academic skills than on the clinical practice of midwifery and finally, the threat of greater control of nursing over midwifery. Others see the change as an opportunity for midwives to learn in an environment which supports the development of confident, independent thinking practitioners and where the

opportunity to learn midwifery in different settings is possible. Some in the profession feel that learning in an academic environment will provide the opportunity for midwives to learn new skills such as research.

Finally, changes in midwifery practice are also occurring. While midwives retain the legal right to practise as autonomous practitioners in NSW, until recently few did so. However, new variations of midwifery practice are now providing the opportunity for midwives to reclaim a more autonomous role. These variations are occurring within the hospital system and include team midwifery, birth centre practice, midwives clinics and early discharge programs. The model of independent (private) midwifery practice is also gaining acceptance within the established health care system. Within this model continuity of midwifery care is provided with the birth occurring either at home or in hospital. Despite these recent changes the overall autonomy of midwifery practise is less than many in the profession would desire.

The issue of professional autonomy was examined in more depth in interviews with key informants. The analysis of these interviews revealed five major themes which midwives consider are critical influences on the degree to which midwifery will achieve greater autonomy. These themes related to the loss of midwifery skills, the process of how midwives learn the skills of their profession, the relationship between midwives and the professions of medicine and nursing, issues within the profession itself and finally midwives' relationship with women.

The implications of the studies' findings as they relate to the development of midwifery in Canada will be discussed in the remainder of this chapter.

9.1 Discussion

For many years Canada was the only industrialised nation in the world in which midwives did not have the legal right to practise. As previously discussed in this thesis, this situation is changing as more and more provinces announce their intent to legalise midwifery and incorporate the services of midwives into their health care systems. These events represent a significant victory for Canadian women, their families, and those midwives who have lobbied for legal recognition despite significant opposition from the established medical community.

The reasons why Canadian women and their families have fought for the legal recognition of midwifery are not unlike those of Australian women who also desire change within their system of maternity care. These reasons include: the desire for continuity of care, less medical intervention in childbirth, and more involvement by women and their families in the decision-making process regarding childbirth (Ontario Report 1987; Alberta Midwifery Services Review Report 1992; Relyea 1992). In NSW, where midwifery is fully integrated into the health care system, these requests have supported a **change** in the role of the midwife, in Canada they have resulted in the **establishment** of a legal role for the midwife.

Evidence from those provinces which have announced their intent to legalize midwifery indicates that while not unanimous, support for midwifery as a self-regulating profession is strong (Ontario Report 1987; Alberta Midwifery Services Review Report, 1992; British Columbia Ministry of Health 1993). The recommendations of these provincial reviews, if acted upon by government, will establish midwifery as a profession

in its own right, distinct and separate from nursing. Therefore, unlike midwives in NSW who face the task of achieving greater control over their profession within the regulatory structure of nursing, Canadian midwives will have achieved a degree of autonomy by securing the right to control the regulatory structure of their profession.

The results of this study of midwifery in NSW indicate that the recognition of a distinct scope of practice and the achievement of the legal right to practise does not necessarily ensure that a profession will be able to fulfil its professional goals. Achieving control over ones' work or the acquisition of professional autonomy at the labour process level, is a complex task which is subject to influence at a number of levels as discussed in this thesis. These influences effect the changing role of midwifery in NSW and will also influence the successful establishment of midwifery in Canada.

Like midwifery in NSW, the autonomy of Canadian midwives will also be subject to the influence of inter-professional issues as well as intra-professional issues. Midwives will have to be prepared with the right balance of skills which will enable them to practise in a variety of settings. The process of acquiring these skills must also occur in environments which support the concept of midwives as practitioners in their own right. Finally, issues around the accessibility of midwifery care and the ability of midwives to fulfil their role as advocates for women must be resolved.

9.1.1 Inter-professional relationships

One significant challenge facing midwives in Canada is the successful establishment of a collegial relationship with both the profession of medicine and nursing,

both of whom have well-established roles in caring for childbearing women. Using the theatre as a metaphor, Kaufert (1992) has suggested that as the new player, the midwife, emerges on the stage, she must be aware that other players with existing roles must move and make way for the new arrival. This will be difficult for some.

Canadian physicians have long held the exclusive right to provide care to women in childbirth. The majority, unless educated elsewhere, have limited exposure to midwives. Unlike physicians elsewhere in the world, they have also never had the opportunity to learn the skills related to the management of normal labour from midwives. In addition, they have not had the opportunity to work with midwives, who function in a midwifery role. Despite this, many in the medical community appear to support, in principle, the legalization of midwifery. However, the extent to which physicians will support midwives functioning autonomously remains uncertain. Evidence from this study and from the literature suggest that the increasing autonomy of midwives is often met with resistance from physicians. The response from physicians is variable, but may include efforts to impose stricter control over the parameters of midwifery practice, or by controlling access to hospital privileges or diagnostic procedures. As midwifery develops in Canada, an opportunity exists to create a framework where such actions are constrained. Components of this framework should include; clear guidelines for consultation and referral, developed jointly by midwives and physicians, limited prescribing rights, direct access to diagnostic facilities for midwives and finally, admitting privileges to hospitals and birth centres for midwives. Despite having mechanisms in place that limit the control of physicians over midwifery practice, the

successful integration of midwifery into the Canadian health care system requires the support of the medical profession. Like midwives in NSW whose efforts to achieve greater autonomy remain somewhat dependant on the backing of physicians, so will the establishment of midwifery in Canada. It is unlikely that all physicians will actively support the introduction of midwifery in Canada. Building on the support of a few and establishing successful practice relationships will be critical. This will provide role models for the further development of midwifery-based models of care. Like their colleagues in NSW, building a collegial basis for these practice relationships may also require both midwives and physicians to re-interpret their views of one another and develop a measure of trust.

In addition to establishing a professional relationship with physicians, midwives must also define their role with the nursing profession. Nurses in Canada generally have supported the legalization of midwifery, but as a specialty of nursing not as a distinct and separate profession. Despite indications that midwifery in Canada will be afforded occupational autonomy (regulatory independence), midwifery will share a close relationship with nursing both in education and practice. If the accepted model of midwifery education is based on the concept of multiple routes to entry, then some Canadian midwives will also have nursing qualifications. The reality of health care provision in Canada, as in Australia, supports this model. It is unlikely that the current health care system can financially support both nursing and midwifery services to rural and remote communities. Therefore preserving the **choice** of nursing as a route for entry to midwifery education appears logical.

Concern for the preservation of scarce educational resources also supports a model of education for midwives which shares common roots (ie. in biological sciences) with nursing, but is further developed as a distinct and separate discipline. This distinctness in the educational process will also allow for the development of a midwifery identity and the ability to be prepared for assuming a primary care role, concerns which midwives in NSW described as limitations to their present nursing-based model of midwifery. In NSW there is no role equivalent to either the Canadian obstetrical nurse or the public health nurse who provides care to mothers and babies in hospital and upon discharge. Both roles are generally assumed by midwives in NSW. Therefore this study is limited in the extent to which its findings provide insight into the potential for role displacement and overlap between nurses and midwives. However, it is likely that the integration of midwifery into the Canadian health care system will result in some degree of displacement of nursing roles, particularly if the principles of continuity of care are maintained. Nevertheless, the work of midwives and nurses will still be closely related. In some cases, existing role relationships will require adjustment, particularly if midwives who previously have functioned as obstetrical nurses now chose to practise as midwives. Although role conflict between nurses and midwives may develop, the origins will be different to those which exist in NSW. There the conflict arises from the degree of control nursing exerts over the regulatory structure of midwifery and to a lesser degree the actual work of midwives. However, as with medicine, the professional relationship between nurses and midwives ideally will develop on a collegial basis as both seek to meet the needs of childbearing women.

9.1.2 Models of practice

The experience of midwives in NSW indicates that achieving greater autonomy was problematic within the existing system of maternity care. Modifications to this system and the creation of new practice models were necessary for midwives to achieve greater independence. These variations included independent practice, team midwifery and birth centre practice. Similarly, midwifery based models of care cannot be superimposed on the existing system in Canada. Changes must also occur in this system in order to accommodate the role of the midwife. Like midwives in NSW, Canadian midwives must be allowed to develop models of care that integrate their philosophy and approach to care. Within these settings of practice, the work of midwives should not be subject to the same control of policies and procedures developed from the medical model of care. These models need not require significant expenditures of funds, but rather involve modification of existing care arrangements and the creation of designated midwifery units or birth centres separate from the larger labour and delivery units. For midwives in NSW, this separation contributed to their ability to integrate a different approach to care and allowed them greater authority to make decisions based on their own assessments and philosophy of care within a hospital environment.

In NSW the availability of midwifery services in hospital has not eliminated (planned) births occurring at home. Like women in NSW, some women in Canada will continue to choose the home as their preferred setting for midwife attended births. In the present Canadian system, midwives who attend home births often do so without the benefit of medical back-up and the circumstances under which transfers to hospital occur

are often less than ideal. This is not unlike the early experiences of midwives in NSW who began to attend births at home and who faced opposition from the established medical community as well as from their midwifery colleagues. The situation in NSW has improved but appears to lack an integrated approach which would facilitate communication and the ease of transfer between home and hospital if complications should occur. The granting of visiting rights to hospital birth centres for independent midwives has increased the available options for women who do not wish to deliver in a traditional hospital setting. As the Canadian system changes to accommodate midwifery, mechanisms are also required which will provide guidelines for home confinements as well as creating a system where midwives who attend home births do not practise in isolation but have access to the larger system if required.

9.1.3 Midwifery skills and education

The findings from this study also provide insight into additional factors within the educational and practice environment that effect the extent to which midwives are able to function in accordance with their scope of practice. These findings suggest that the preservation of the basic skills of the midwife are a critical element in the ability of the midwife to provide care "on her own responsibility". Confidence in the use of these skills is also an important variable in the ability of the midwife to function competently in settings without fixed technology. However, the ability to use and interpret a select range of obstetrical technology (ie. electronic fetal monitoring) are also skills that midwives must possess, particularly if they are to base their practice in hospital settings

and participate in the care of women experiencing complications of pregnancy. Midwives, then must be prepared with the correct **balance** of skills that will prepare them for practice in a variety of settings. The findings of this study also indicate that the "hands on skills" of the midwife are skills that are particularly vulnerable to erosion in educational and practice settings where the use of technology is highly valued. Finally, fragmentation in the role of the midwife in NSW has resulted in a loss of the overall skills of the midwife and a decrease in the ability of midwives to provide care to women throughout pregnancy, birth and into the post partum period. These findings are important to consider as models of education and practice are developed for midwives in Canada.

9.1.4 Intra-professional issues

Like midwives in NSW, Canadian midwives must also resolve issues within the profession which prevent the development of a unified approach to achieving common goals. Unlike midwives in NSW where the majority have formal midwifery preparation, Canadian midwives come from both lay and nursing backgrounds. Conflict has often characterised relations between these two groups of midwives. While nurse-midwives have always been in the majority, most have not been as actively involved as lay midwives in efforts to legalise midwifery in Canada. In many cases they have been more inclined to accept the status quo, and have not actively challenged the system. In contrast lay midwives in Canada, like independent midwives in Australia, have exerted a greater degree of influence in changing the system than their small numbers would

suggest. Evidence from the Canadian context (Relyea 1992) suggests that efforts to achieve change are far more effective when both groups of midwives join together with women.

Both groups of Canadian midwives bring diverse experiences and skills to the care of women in pregnancy and childbirth. In developing midwifery in Canada, the challenge will be to integrate the skills and experiences of both groups in a manner in which is consistent with the goals of midwifery and in which the value of each is acknowledged.

It is difficult to determine the number of nurse-midwives in Canada but as some have suggested they are an under utilized resource (Manitoba Joint Report 1991). It is also uncertain how many wish to resume practising midwifery. Many have well established roles as obstetrical nurses within the existing health care system and their skills and confidence to practise as midwives has been significantly erode. Those who choose to return to midwifery will face the task of "re-skilling" themselves as midwives. Their situation will not be unlike that of midwives in NSW who have had to relearn old skills and acquire new ones, as they accept the challenge of assuming a more autonomous role.

Similarly, empirically trained midwives who have long practised in isolation from the established health care system, will have to learn selected skills-enabling them to expand their practice to provide care to women in a variety of settings not exclusively in the home.

9.1.5 Women and midwives

Ironically, despite having legal recognition, midwives in NSW expressed the need to re-educate women about the role of the midwife. Educating the public regarding the role and value of midwifery care is also a challenge facing Canadian midwives. In both Canada and Australia, primary care in childbirth by specialist obstetricians has become the accepted norm. In the case of Australia it is also a symbol of economic wealth, since only those with financial means can afford to purchase private health insurance which covers the services of private obstetricians. In both countries a view that midwifery care is second to that physician care is a concept that requires action, so that the benefits of midwifery care become known to and sought by the mainstream public.

The common practice of linking the issue of midwifery and that of home delivery has contributed to the development of a narrow view of midwifery by the public. Broadening the public's view regarding the role of the midwife will be enhanced by having midwifery services highly visible and accessible to women in a variety of settings.

Removing the barriers that limit the accessibility of continuity of care by midwives is an issue that concerned many midwives in NSW. In the NSW these barriers included the lack of Medicare or Private health insurance funds for independent midwives and the limited geographic availability of midwifery-based models of care within the publicly funded system. Ensuring that midwifery care is an insured service within the Canadian health care system will remove the major barrier of finances.

However, the greater challenge for Canada, like Australia will be to develop and integrate midwifery services into rural and remote areas of the country. In Canada, this will require a re-examination of the policy of evacuating all women living in remote areas to larger centres for delivery, once midwives are available to provide services to these areas. One would also hope that returning childbirth to these communities will stimulate the recognition and integration of traditional midwifery and birth practices of indigenous people and as well as those of the growing multicultural community in Canada. In both countries models of care such as Povungituk in Northern Quebec, and its parallel the Congress Alukura in Central Australia are available. However, making culturally appropriate midwifery services widely available to all women remains a significant challenge for both countries. Finally, the fight for legalization of midwifery in Canada and the struggle to reclaim an independent role for midwives in NSW share a common basis. That is, the belief that midwifery-based care results in improved outcomes for women in childbirth. This belief is based on the view that childbirth is an essentially normal human experience. The criteria for measuring success in childbirth therefore should include measures such as rates of medical intervention, the amount of support and advice provided and womens's satisfaction with the birth experience, **in addition** to measures such as morbidity and mortality. Seen in this way the legalization of midwifery in Canada and greater autonomy for midwives in Australia will only improve the system of maternity care provided and result in an reduction in overall cost to the health care system. These issues are of mutual concern to policy makers in

Canada and Australia as they consider ways to more appropriately utilize ever dwindling health care resources.

BIBLIOGRAPHY

Abbott, L. (1985). The Central Australian Aboriginal Congress Birthrights Research and Birthrights Program. Conference proceedings. *Women's Health in a Changing Society*, 2, 1-4.

Abbott, L. (1988). Alukura. By the grandmothers' law. *ACMI Journal*, June, 8-9.

Adcock, W., et al. (1984). *With courage and devotion - A history of midwifery in New South Wales*. New South Wales Midwives Association Anvil Press, Marrickville, New South Wales.

Advanced nursing studies certificate course curriculum. (2nd ed.). (1991). Glebe, New South Wales: New South Wales College of Nursing.

American College of Nurse-Midwives. (1992). *Position Statement on Midwifery Education*.

Annandale, E. (1989). Proletarianization or restratification of the medical profession? The case of obstetrics. *International Journal of Health Services*, 19, 611-634.

- Arney, R. (1982). *Power and the profession of obstetrics*. University of Chicago Press.
- Australian Bureau of Statistics. (1990). *Health Insurance Survey*.
- Australian Bureau of Statistics. (1992). *Pocket Year Book of New South Wales*. 75. Commonwealth of Australia.
- Australian Institute of Health. (1988). *Information Bulletin*. Health Care Expenditures.
- Australian Society of Independent Midwives*, 1991. (Communique). Editor - Formation of Asim, 3(2).
- Australian Society of Independent Midwives*, 1992. (Communique). Advertisement for Home Birth Midwives.
- Australian Society of Independent Midwives Academy*, 1993. Information Bulletin.
- Barclay, L.M. (1985). Australian midwifery, training and practice. *Midwifery*, 1, 86-96.

- Barclay, L.M. (1985). *The midwife: An endangered species*. Paper presented at the National Midwives Conference, Brisbane.
- Barclay, L.M., Andre, C. & Glover, P.A. (1989). Women's business: The challenge of childbirth. *Midwifery*, 122-133.
- Barrington, E. (1985). *Midwifery is catching*. Toronto: N.C. Press Ltd.
- Bastian, H. (1991). *Giving birth at home. A guide for Australian parents. Homebirth Australia Inc.* Katoomba, New South Wales: Brownlee.
- Bayliss, V. (1981). *Midwifery manpower study*. Health Commission of New South Wales.
- Bennett, C. & Shearman, R. (1989). Maternity Services in New South Wales - Childbirth moves toward the 21st century. *Medical Journal of Australia*, 150, 673-676.
- Benoit, C. (1991). *Midwives in passage*. Published by Memorial University Newfoundland Institute of Social and Economic Research.

Biro, M. & Lumley, J. (1991). The safety of team midwifery: The first decade of the Monash Birth Center. *The Medical Journal of Australia*, 155, 478-481.

Birth 2000. (1991). *Who will deliver the women of tomorrow?* Meeting proceedings. Published by the Royal Australian College of Obstetricians and Gynaecologists. Melbourne.

Breece, C., Israel, E. & Friedman, L. (1989). Closing of the nurse-midwifery service at Boston City Hospital. What were the issues involved? *Journal of Nurse-Midwifery*, 34, 41-48.

Broome, D. (1984). Medicalization of childbirth: A new role for the midwife. *Health Report*, 4, 10-14.

Chalmers, I., Enkin, M. & Keirse, M.J.N.C. (eds.). (1989). *Effective care in pregnancy and childbirth*. Oxford. Oxford University Press.

Coburn, D., Torrance, G. & Kaufert, J. (1983). Medical dominance in Canada: An historical perspective: The rise and fall of Medicine? *International Journal of Health Services*, 13, 407-432.

Coburn, D. (1988). The development of Canadian nursing: Professionalization and Proletarianization. *International Journal of Health Services*, 18, 437-457.

Coburn, D. (1989). *Freidson then and now: An "internalist" critique of Friedson's past and present views of the medical profession*. University of Toronto. Unpublished paper.

College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses. (1991). *Report on the Future Role of Midwives in Manitoba*. Winnipeg, Manitoba.

Collins, P. (1991). *Nurses Bill 1991*. Speech to the Legislative Assembly, New South Wales Parliament, March 20, 1991.

Commonwealth of Australia (1989). *National women's health policy*. Government Printing Service. Canberra.

Conrad, P. & Schneider, W. (1990). *Professionalization, monopoly and the structure of medical practice*. In: *Sociology of health and illness - critical perspectives*.

Conrad, P. & Kern, R. (eds.). New York: St. Martin's., 141-145

- Cull, E. (1993). *Legalization of midwifery in British Columbia*. Address to International Congress of Midwives Conference. Vancouver.
- D'Elmaine, J. (1991). *The alternative birthing services program and its implications for midwifery practice*. Paper presented at the Australian Nursing Federation Conference.
- D'Elmaine, J. (1991). *Midwifery commitment - words or actions*. Paper presented at the New South Wales Midwives Association Annual Conference. Dubbo.
- D'Elmaine, J. (1992). Letter to the Editor Re: Changes to the NSW Nurses Act. *Communique, 4 (4)*.
- Davis-Floyd, R. (1990). The role of obstetrical rituals in the resolution of cultural anomaly. *Social Science Medicine, 31*, 175-189.
- Davis-Floyd, R. (1987). The technological model of birth. *Journal of American Folklore, 100*, 480-495.
- Davis, A. & George, J. (1988). *States of health: Health and illness in Australia*. Sydney: Harper & Row.

Dent, J. (1991). Personal communication.

Department of Health NSW. (1989). Maternal and perinatal report. *Report from the Epidemiology and Health Services Evaluation Branch, Department of Health, New South Wales.*

Devereux, L. (1990). Alukura - the women's camp. *Home Birth Australia*, 22, 4-6.

DeVries, R. (1986). Barriers to nurse-midwifery. Is the enemy us? *Journal of Nurse-Midwifery*, 31, 277-278.

DeVries, R. (1989). *Care givers in pregnancy and childbirth*. In: Effective care in pregnancy and childbirth. Chalmers, I., Enkin, M., & Keirse, M.J.N (eds.). Oxford: Oxford University Press., 143-158.

Dewdney, J. (1989). *The Australian health care system: an overview*. In: Sociology of health and illness - Australian readings. Lupton, G. & Najman, J. (eds.). MacMillan company of Australia., 71-100.

Donnison, J. (1977). *Midwives and medical men*. New York: Schocken Books.

- Field, P.A. (1991). *A report on health care in the United Kingdom with particular reference to midwifery*. Unpublished report.
- Flint, C. (1986). *Sensitive midwifery*. London: Heinemen.
- Flint, C., Poulengeris, P. & Grant A. (1989). The know your midwife scheme - a randomized trial of continuity of care by a team of midwives. *Midwifery*, 5, 11-16.
- Friedson, E. (1977). *Professional prominence*. New York: Atherton.
- Friedson, E. (1970). *Profession of medicine*. New York: Harper and Row.
- Garcia, J., Garforth, S., & Ayers, S. (1985). *Midwives confined?* In: Labour Ward Policies and routines. Thomson, A., & Robinson, S. (eds.) Research and the midwife conference proceedings. Kings College, University of London.
- Giles, W., Collin, J., Ong, F., & McDonald, R. (1992). Antenatal care of low risk obstetric patients by midwives: A randomized controlled trial. *The Medical Journal of Australia*, 157, 158-161.
- Gleeson, M. (1991). *Implementation of the Shearman Report*. Paper presented to Birth 2000 Conference. Sydney.

- Graham, S. (1991). A structural analysis of physician-midwife intersection in an obstetrical training program. *Social Science and Medicine*, 32, 931-942.
- Green, J., Kitzinger, J. & Ceuphano, V. (1986). *The division of labour*. Cambridge: University of Cambridge Child Care and Development Group.
- Griffiths, P. & Wass, A. (1991). New threats to midwifery practice? *Midwifery Matters*, 5, Number 3, 12-21.
- Haertsch, M. (1991). Letter to Mr. John Hatton. *Midwifery Matters*, 5.
- Hancock, H. (1992). Midwifery education - Whether will we wander? *Australian College of Midwives Inc. Journal*, 5, 26-29.
- Having a baby in Europe*. (1985). World Health Organization. Report from the Regional Office for Europe. Copenhagen.
- Hayes, P. (1992). *Glimpses in the looking glass or nothing new under the sun*. Paper presented at the 1992 New South Wales Midwives Association State Conference. 2-14.

- House of Commons Health Committee Second Report. (1992). *Maternity services*.
Published by Her Majesty's Printing Office. London.
- Howe, B. (1991). *Alternative birthing services program: Media releases*. Department
of Community Services, Canberra.
- Intervention in Childbirth in Australia*. (1991). Maternity Alliance, Guide to
Recommendations of the World Health Organization. Article 1, Pg. 1.
- Jacobson, A. (1993). Are we losing the art of midwifery? *Journal of Nurse-Midwifery*,
38, 168-169.
- James, M., Hudson, C., Gebski, V., Browne, L., Andrews, G., Crisp, S., Palmer, D.,
Beresford, J. (1987). An evaluation of planned early postnatal transfer home with
nursing support. *The Medical Journal of Austral*, 147, 434-438.
- Johnson, J.C. (1990). *Selecting ethnographic informants*. Newbury Park, CA: Sage.
- Kaufert, P. (1992). *Evaluating care by midwives: impact on the system - other
providers and clients*. National Invitation Workshop on Midwifery Research and
Evaluation. Ottawa.

- Kilver, T. (1976). *Task analysis of obstetric care: An investigation of the health services morbidity study (Gilpatrick) method*. Hospitals and Health Services Commission, New South Wales.
- Kitzinger, S. (ed.). (1988). *The midwife challenge*. London: Pandora.
- Kostrzewa, C. & Rowley, M. (1992). *Do birth centers remove options for childbearing families?* Paper presented at the 1992 New South Wales Midwives Association State Conference.
- Lecky-Thompson, M. (1993). Personal communication.
- Lewthwaite, B. & Robinson, K. (1987). *Midwifery and technology*. Paper presented at the 21st International Congress of Midwives Conference. The Hague, Netherlands.
- Lichtman, Ronnie. (1988). *Medical models and midwifery: The cultural experience of childbirth*. In: *Childbirth in America - Anthropological perspectives*. Michaelson, K. (ed.). South Hadley, Mass: Bergin & Garvey Publishers.
- Love, I. (1979). *The history of midwifery training in Australia*. National Midwives Association Conference, Adelaide.

- Lumley, J. & Ashburg, J. (1980). *Birth rights, birth rites*. Melbourne: Sphere.
- Marshall, C. & Rossman, G. (1989). *Designing qualitative research*. Newberry Park: Sage.
- Maternal and perinatal care in New South Wales*. (1989). New South Wales Department of Health.
- Maternity Services in New South Wales*. (1989). The Final Report of the Ministerial Taskforce on the Obstetric services in New South Wales.
- McCool, W.F. & McCool, S. (1989). Feminism and nurse-midwifery. *Journal of Nurse Midwifery*, 34, 323-334.
- McDonell, A. (1991). Australian midwifery reflections in the final decade of the century. *Australian College of Midwives Inc. Journal, September*, 15-23.
- Meppem, J. (1991). Personal communication.
- Michaelson, K. (1988). *Childbirth in America - Anthropological perspectives*. Massachusetts: Bergin & Garvey.

Midwifery: A discussion paper. (1987). Manitoba Advisory Council on the Status of Women.

Midwifery Matters. (1992). 6(3). Re: Team Midwifery.

Nelson, B. (1993). *Address to the National Press Club on behalf of the Australian Medical Association.*

Newby, L. (1989). *"The Politics of women's health". Midwives-from Handholders and Handmaidens and back.* Paper presented at the Australian College of Midwives, Inc. Biennial Conference. Darwin.

New South Wales Maternity Services - An update implementation of the Shearman Report. (1991). Services and Capital Planning Branch. New South Wales Health Department.

New South Wales Nurses Registration Board. (1990). History of the New South Wales Nurses Registration Board. Sydney.

O'Donnell, R. (1991). *Why birth centres?* Paper given at the King George V Golden Jubilee Scientific Meeting, Sydney.

Oakley, A. (1980). *Woman confined.* New York: Schocken.

- Oakley, A. (1984). *The captured womb. A history of medical care of pregnant women.*
Oxford: Blackwell.
- Oakley, A. (1989). Who cares for women? Science vs. love in midwifery today.
Midwives Chronicle and Nursing Notes. July, 214-220.
- Oakley, A. & Houd, S. (1990). *Helpers in childbirth - Midwifery today.* Published
on behalf of the World Health Organization. Regional Office for Europe. London:
Hemisphere.
- Palmer, G. & Short, S. (1989). *Health care and public policy - An Australian
analysis.* South Melbourne: The MacMillan Company of Australia.
- Pettingil, L. (1990). Public Policy - Power - Professionalism. *Australian College of
Midwives Journal, December, 23-28.*
- Phillips, R.A. (1991). Letter to Mr. B.L. Jeffery. *Midwifery Matters* 5 (3).
- Purcal, K. (1985). *The education, training and registration of midwives in New South
Wales, 1875 to 1935.* Thesis: Master of Education, the University of New England.

- Reid, J. (1983). *Sorcerers and Healing Spirits: Continuity and Change in an Aboriginal Medical System*. Canberra: Australian National University Press.
- Relyea, J.M. (1992). The rebirth of midwifery in Canada: An historical perspective. *Midwifery*, 8, 159-169.
- Report of the Midwifery Service's Review Committee*. (1992). Government of Alberta.
- Report on complaints about lay-birth attendants*. (1991). The Complaints Unit, New South Wales Health Department, 10.
- Report of the working party on the care of pregnant women in remote areas*. (1984). Commonwealth of Australia. Canberra.
- Rich, A. (1975). The theft of childbirth. *New York Review of Books*, 22, 25-36.
- Robinson, J. (1992). *Independent midwifery practice - A guide for students and practitioners of midwifery*.
- Robinson, J. (1992). Editor - *Midwifery Matters Re: Unauthorized use of title 'midwife'*, 6(3).

- Robinson, S. (1983). *From independent practitioner to team member; Some aspects of the history of the midwifery profession*. In: Understanding politics - An historical perspective. White, R. (ed.). London: King's Fund Center.
- Robinson, S. (1985). Normal maternity care: Whose responsibility? *British Journal of Obstetrics and Gynaecology*, 92, 1-3.
- Robinson, S. (1989). *The role of the midwife: opportunities and constraints*. In: Effective care in pregnancy and childbirth. Chalmers, I., Enkin, M. & Keirse, M.J.N.C. (eds.). Oxford: Oxford University Press, 162-180.
- Romalis, S. (1981). *Childbirth alternatives to medical control*. Austin: University of Texas Press.
- Rothman, B. (1984). Childbirth management and medical monopoly midwifery as (almost) a profession. *Journal of Nurse-Midwifery*, 29, 300-306.
- Rothman, B. (1990). *Midwives in transition: The structure of a clinical revolution*. In: The Sociology of health and illness. Critical Perspectives (Third Ed.). Conrad & Kern (eds.). New York: St. Martin's Press.

- Roumieh, H.N. (1992). *Cultural mores, religious doctrine, mothers and babies*. A paper presented at the 1992 New South Wales Midwives Association State Conference.
- Rowley, M. & Saxton, A. (1992). *Team midwifery: The Newcastle experience*. Paper presented at the New South Wales Midwives Association, State Conference.
- Ryan, M. & Gabb, R. (1991). Perceptions of obstetric practice: A survey of the members of the Australian College of Midwives. *Australian College of Midwives Journal, September*, 8-11.
- Sax, S. (1989). *The politics of health in Australia*. In: *Sociology of health and illness - Australian readings*. Lupton G. & Najman, J. (eds.). MacMillan Company of Australia, 101-120.
- Schlatter, B. (1991). Nurse-midwifery: The profession and the challenge it faces. *Journal of Perinatal Neonatal Nursing, 5*, 25-33.
- Scully, D. (1980). *Men who control women's health*. Boston: Houghton Mifflin.
- Short, S. & Sharman, E. (1989). *Dissecting the current nursing struggle in Australia*. In: *Sociology of health and illness - Australian readings*. Lupton G. & Najman, J. (eds.). MacMillan Company of Australia, 225-235.

- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Stenning, E.M. (1989). *A survey of the tasks performed by midwives in New South Wales Hospital based prenatal clinics*. Report of a Post Graduate Project for a degree of Master of Arts.
- Sullivan, D. & Weitz, R. (1988). *Labor pains - Modern midwives and home birth*. New York: Yale University Press.
- Task Force on the Implementation of Midwifery in Ontario Report*. (1987). Toronto: Ministry of Health.
- Tew, M. (1990). *Safer childbirth?* London: Chapman and Hall.
- Thomson, N. (1989). *Aboriginal health: A socio-cultural perspective*. In: *Sociology of Health & Illness - Australian Readings*. Lupton, G. & Najman, J. (eds.). MacMillan Company of Australia.
- Thompson, A. (1990). Medical confusion on care in childbirth and the role of the midwife? *Midwifery*, 6, 57-59.

- Thornton, A. (1972). The past in midwifery services. *Australia Nurses Journal*, 1(9), 19-23.
- Van Der Klei, J. (1991). *The past and future of midwifery education in New South Wales*. Paper presented to King George V Memorial Hospital for Mothers and Babies. Golden Jubilee.
- Varney Burst, H. (1990). "Real" midwifery. *Journal of Nurse-Midwifery*, 36, 189-191.
- Walker, G. (1990). *Birth: A contest for control*. An analysis of the ministerial task force to review obstetric services in New South Wales. Master in Administration Project, University of Technology, Sydney. Unpublished.
- Walker, J. (1976). Midwife or obstetric nurse? Some perceptions of midwives and obstetricians on the role of the midwife. *Journal of Advanced Nursing*, 1, 129-138.
- Willis, C. (1989). *Direct-entry midwifery*. Paper presented at the Australian College of Midwives, Inc., Darwin.
- Willis, E. (1989). *Medical Dominance*. Sydney: Allen & Unwen.

Willis, E. (1989). Doctoring in Australia: A view at the bicentenary. *The Milbank Quarterly*, 66(2).

Women's Health Services in New South Wales. (1985). Final Report of the Women's Health Policy Review Committee. Government of New South Wales.

Yin, R. (1989). *Case study research: Design and methods*. Newbury Park: Sage.

APPENDICES

APPENDIX 1: Definition and Core Competencies of the Midwife

NSW NURSES REGISTRATION BOARD

GUIDELINES FOR MIDWIFERY EDUCATION PROGRAMMES

It has now been three years since the New South Wales Nurses Registration Board, in consultation with midwifery representatives, developed guidelines, competencies and clinical experience requirements to assist course planners in health and higher education institutions to prepare courses leading to an Authority to Practise Midwifery. In order to accommodate change, this information has now been reviewed.

The Board continues to require that midwifery education programmes prepare graduates to meet these competencies and clinical experience be planned to develop the necessary skills. A suggested list of midwifery experiences is included to assist course planners in the development of programs leading to an Authority to Practise Midwifery.

The Board's Philosophy

The Board accepts that -

"A midwife is a person who having been regularly admitted to a midwifery education program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, health units, clinics, domiciliary conditions or in any other service." ⁽¹⁾

(1) Definition of a midwife adopted by the International Conference of Midwives and International Federation of Gynaecologists and Obstetricians in 1972 and 1973 respectively, and following amendment by the World Health Organisation.

(2) The Board accepts the World Health Organisation definition and that words imparting the female gender shall include the male.

In broad terms, the programme shall equip a graduate to be able to assume responsibility for -

- * Providing a high standard of health care for the family unit during the prenatal, labour and puerperal periods regardless of the chosen environment.
- * Educating the woman and her family, the community, students of midwifery and other health disciplines, and themselves regarding all aspects of reproductive health.
- * Undertaking and utilising research findings leading to improved practice.
- * Continuously evaluating practice, revising as necessary to maintain high professional standards.

The programme shall promote the ability to co-ordinate and collaborate with others to achieve optimal consumer care which recognises the patients' right of choice. It is expected that graduates will subscribe to those principles developed by their national association.

The following points are drawn to the attention of health and higher education institutions conducting programmes which lead to the granting of an Authority to Practise Midwifery:

1. The Board accepts the entry requirements determined by individual education institutions, provided that the applicant is registered as a nurse in New South Wales.
2. Courses must be assessed and approved by the New South Wales Nurses Registration Board before commencement. Submissions should be made to the Board at least three (3) months prior to the proposed commencement date. To assist higher education institutions in the development of programmes leading to an Authority to Practise Midwifery, additional guidelines regarding requirements for approval of clinical experience areas have been prepared and are attached.
3. The Nurses Registration Board will continue to monitor programmes leading to an Authority to Practise Midwifery and requires to be notified of any significant changes in the clinical or theoretical content of the programme.
4. The Nurses Registration Board reserves the right to assess candidates for an Authority to Practise Midwifery by examination, except where exemptions apply.

5. The Nurses Registration Board expects that courses leading to an Authority to Practise Midwifery will have a practical component which correlates to theoretical studies. Clinical education should be organised within institutions and other health agencies in a way which will enable students to best meet the competencies of the midwife. The Board accepts that simulation techniques and laboratory experience are an important part of practical experience.
6. It is expected that students will cover the clinical component of the course within Australia.
7. Where a student midwife is absent from a hospital-based course for a period in excess of five (5) weeks, the period of the course shall be extended to make up leave in excess of this period.
8. The Board reserves the right to assess and monitor the available clinical experience proposed for students' clinical education as well as the staff available to assist the student.
9. The Board expects that experienced midwives who hold appropriate qualifications be involved in the development of the curriculum and in the teaching of both theoretical and clinical components of the course.
10. In order to be eligible for an Authority to Practise Midwifery, students must complete an approved course, meet all requirements of the institution conducting that course and meet the competencies required by the Nurses Registration Board.

NEW SOUTH WALES NURSES REGISTRATION BOARD
COMPETENCIES OF THE MIDWIFE

Competency 1 - ASSESSMENT

The midwife should be able to:

- * assess and monitor in the context of the family unit according to age, well being, socio cultural background and environment, the physiological, psychological, sociological and spiritual needs of:
 - 1) a woman during pregnancy, labour and the puerperium; and
 - 2) her fetus/infant during pregnancy, labour and the neonatal period

Objectives

In developing this competency, the student midwife should be able to:

- * demonstrate skill in applying a problem-solving approach to assessment and monitoring.
- * demonstrate an understanding of the rationale which forms the basis of a midwifery assessment.
- * apply principles of midwifery and related sciences to the process of assessment and monitoring.
- * recognise changes in the health status of a woman and her fetus/infant.

Competency 2 - PLANNING & INTERVENTION

The midwife should be able to:

- * plan and provide appropriate midwifery care to meet the needs of the woman, her fetus/infant and family during pregnancy, labour and puerperium.

Objectives

In developing this competency, the student midwife should be able to:

- * demonstrate a problem-solving approach to the planning of individual care.
- * develop care plans and modify these in accordance with the needs of the woman and her fetus/infant

- * perform clinical midwifery skills.
- * demonstrate an ability to assist in meeting the individuals' physiological and psychosocial needs.
- * apply principles of midwifery and related sciences to the practice of maternal and child health care.

Competency 3 - SAFETY

The midwife should be able to:

- * provide for and advise on security and safety for the woman, her fetus/infant and family during pregnancy, labour and puerperium.

Objectives

In developing this competency, the student midwife should be able to:

- * display an attitude of safety consciousness in the planning and delivery of maternal and child care.
- * identify situations which require referral to other members of the health care team.
- * evaluate the adequacy of safety precautions.
- * demonstrate an understanding of legal and ethical responsibilities in relation to midwifery intervention.
- * recognise the need of the individual for support, security and self esteem.

Competency 4 - HEALTH PROMOTION

The midwife should be able to:

- * assume a health promoting role regarding pregnancy, labour, puerperium and the neonatal period for women, their families, groups and health professionals.

Objectives

In developing this competency, the student midwife should be able to:

- * identify the reproductive health needs within the Community.
- * participate in and evaluate health promotion programs.
- * apply knowledge of educational principles and the physical, biological and behavioural sciences to the development of health promotion programs.

- * understand the principles of the development of training/education programs in maternal and child health relating to all ages, levels of ability and groups.

Competency 5 - HABILITATION/REHABILITATION

The midwife should be able to:

- * participate with the woman, her family and multi-disciplinary team in setting goals in relation to habilitation/rehabilitation and in planning, implementing and evaluating strategies for meeting these goals.

Objectives

In developing this competency, the student midwife should be able to:

- * discuss strategies to modify the activities of daily living to accommodate childbearing and mothering needs.
- * assist the woman and her family in the development of parenting skills.
- * evaluate programs in relation to pregnancy and parenting.

Competency 6 - COMMUNICATION AND INTERPERSONAL SKILLS

The midwife should be able to:

- * utilise interpersonal communication skills in meeting the individual needs and concerns of the childbearing woman, her family and others.

Objectives

In developing this competency, the student midwife should be able to:

- * apply communication and interpersonal skills to the assessment and monitoring of individual needs and concerns.
- * demonstrate the ability to apply communication and interpersonal skills throughout the process of the planning and giving of individualised care with families and other members of the health team.
- * demonstrate the ability to apply communication and interpersonal skills in the education of the woman, her family and the community.
- * identify and resolve own difficulties in communication.

Competency 7 - MANAGEMENT OF PROFESSIONAL PRACTICE

The midwife should be able to:

- * apply management principles in the planning and provision of midwifery care and to professional practice.

Objectives

In developing this competency, the student midwife should be able to:

- * apply the principles of management to the organisation of clinical midwifery practice.
- * demonstrate qualities of leadership and management in the delivery of midwifery care.
- * plan and provide health care:
 - 1) based on health needs and rights of a family during their reproductive years.
 - 2) in accordance with scientific and problem-solving principles.
 - 3) consistent with relevant policies and practices.
- * assess and evaluate the quality and effectiveness of care provided by self and/or others.
- * recognise the need for continuing education.
- * demonstrate an ability to understand the principles of research methodology.

NEW SOUTH WALES NURSES REGISTRATION BOARD

SUGGESTED MINIMUM MIDWIFERY EXPERIENCE

The student midwife shall, under the direct supervision of a registered midwife or medical officer -

1. Conduct at least 20 pre-natal examinations on pregnant women, which shall include estimation of blood pressure, examination of the breasts, abdomen, vulva and legs.
2. Make at least ten (10) pelvic examinations which may be gained during pregnancy, labour or puerperium.
3. Manage the nursing care of no fewer than 20 pre-natal cases of complicated pregnancy.
4. (a) Witness -
 - a minimum of 5 normal deliveries prior to conducting a normal delivery;
 - show evidence of having witnessed a number of complicated deliveries, for example, forceps delivery, breech delivery, caesarean section, multiple pregnancies or other complications
- (b) Conduct not fewer than 20 cases of labour, including the 3rd stage. These cases should include at least 15 spontaneous deliveries. No more than five (5) cases in the total of 20 may be made up of any of the above complicated deliveries.
- (c) It is expected that the student midwife obtains experience in the use of a variety of fetal monitoring methods, ie, Pinards and electronic.
- (d) Assist in the management of pain of at least 20 women in labour, utilising a variety of techniques:
 - (i) preparing for, assisting with and caring for women having epidural anaesthesia;
 - (ii) administering inhalation analgesia by means of approved apparatus;
 - (iii) use of intra-muscular analgesics;
 - (iv) observing and assisting with other methods such as psychoprophylaxis, hypnosis and acupuncture..
- (e) Perform at least 2 episiotomies.
 - (i) observe or assist with, or perform under supervision, local infiltration of the perineum;
 - (ii) it is considered desirable that student midwives receive experience in the repair of the perineum in uncomplicated cases.
5. (a) Attend at least five (5) demonstrates of active resuscitative methods in the neonate; for example, use of intermittent positive pressure respiration, endotracheal intubation.
- (b) Attend at least two (2) caesarean sections to assist with the care of the baby after delivery.
6. Introduce the catheter and conduct at least five (5) tube feedings of the neonate.
7. Provide supervision and instruction on a minimum of ten (10) occasions for mothers undertaking breast feeding.
8. Conduct at least two (2) teaching sessions on a midwifery topic to be negotiated with the midwifery educator.

APPENDIX 2: Consent For Participation

CONSENT FOR PARTICIPATION

I hereby consent to be interviewed for this case study of midwifery in New South Wales. The purpose of the study has been explained to me by the researcher, Kristine Robinson. I am also aware that comments made during this interview will not be attributed to me with out my written consent, nor will I be identified by name or place of employment. I am also aware they I have the right to refuse to answer any questions asked by the researcher, and to with draw from the interview at any time without penalty.

Name:

Date:

APPENDIX 3: Interview Schedule

The purpose of the interviews conducted for this study was to discuss with midwives, the changes that had occurred in the profession over time, and to identify major issues that midwives considered significant in the profession's attempt to achieve greater autonomy. In addition, each midwife's "history" as a midwife was also an area of interest. The interview schedule was comprised of a series of open-ended questions that were used to guide the discussion. In most cases the questions were modified as the interview progressed. While some respondents offered additional data, all contributed information on the following general areas of inquiry:

1. Personal history as a midwife: Type of education, work history, significant events that influenced direction of midwifery career. Perspective on childbirth, philosophy of birth.
2. Present area of midwifery work: description of midwifery practice, degree of autonomy, changes in autonomy over time, professional issues in current place of practice. These questions would be modified depending on the respondent's area of work i.e. practice, education, administration.
3. Identification of barriers to achieving professional autonomy i.e. relationships with other professional groups, interprofessional issues, educational/policy issues.
4. Future perspectives on midwifery: Policy recommendations regarding midwifery and maternity care in the state, nationally.
5. Advice for Canadian midwives.

APPENDIX 4: Classification of Obstetric Hospitals In New South Wales

Level 1 - Local Hospitals (no births)

Postnatal only. Postpartum mothers and babies delivered elsewhere may be returned to local hospital provided there are no complications. Midwives and/or mothercraft nurses available.

Level 2 - Small isolated Hospitals

Low risk deliveries only. Staffed by general practitioners and midwives. Facilities available to cope with sudden unexpected risks until recovery or transfer.

Level 3 - Country district or smaller metropolitan Hospitals

Deliveries and care for mothers and babies at low/moderate risk. Full resuscitation, theatre facilities available. Rostered obstetricians, resident medical staff and midwives. Accredited general practitioners/specialist anaesthetic on-call. Has level 4 neonatal service.

Level 4 - Country Base/metropolitan Hospitals

Deliveries and care for mothers and/or babies with moderate risk factors. Obstetrician and paediatrician available 24 hours days/7 days a week. Rostered medical staff, including diploma trainees, specialist anaesthetist on call. Has level 3 neonatal service.

Level 5 - Country Base/metropolitan district hospitals (in some cases regional perinatal centers)

Deliveries and care for babies known to be high risk. Able to cope with complications arising from these risk factors. Research ability. Support commensurate to this level of service. Retrieval capacity. Has level 4 neonatal service.

Level 6 - Special Obstetric Hospitals (supra regional)

All functions-low, moderate and high risk deliveries. Registrars in Obstetric training with specific skills. Some midwives with additional post-graduate qualifications. Level 6 obstetric units should have more than 3,500 deliveries a year and/or meet specific regional or supra regional obligations. Has level 5 neonatal service.

Source: New South Wales Midwives Data Collection 1991
Epidemiology and Health Services Evaluation Branch
NSW Health Department.

APPENDIX 5: Study Protocol

Subject Heading: Midwifery Education

HISTORYDATA SOURCE

Critical Dates/Time Periods

Document Ref, Int #

Specifics:

- ie. elimination of education for non-nurse midwives
 - issues/timing of transfer to tertiary sector
 - Role of hospital/service needs

CONTENTBasic Midwifery Education:

- ie. Organization
 - Length/Academic level of program
 - Philosophy
 - Core competencies
 - Location/Didactic vs. clinical experience
 - Curriculum Hospital vs. tertiary
 - Limitations of current system
 - Who teaches clinal skills?

Continuing Midwifery Education:

ie. Source/Location

Objectives

Funding

Accessibility

Demand

ISSUES IDENTIFIED

QUESTIONS REQUIRING FURTHER INVESTIGATION

APPENDIX 6: Midwives Data Collection

N.S.W. MIDWIVES DATA COLLECTION

Unit Record Number	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HOSPITAL	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(1st Name)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Family Name	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address	_____		
	Postcode _____		
D.O.B. Mother	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Country of Birth (Mother)	Australia <input type="checkbox"/> England <input type="checkbox"/> Lebanon <input type="checkbox"/> New Zealand <input type="checkbox"/> Philippines <input type="checkbox"/> Vietnam <input type="checkbox"/> Other _____
Patent Classification	Hospital <input type="checkbox"/> Private <input type="checkbox"/>	Ethnic Origin (Mother)	Caucasian <input type="checkbox"/> Aboriginal <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/>
Marital Status	Married/Defacto <input type="checkbox"/> Never Married <input type="checkbox"/> Div./Sep./Wid. <input type="checkbox"/>	Place of Birth (Baby) Hospital <input type="checkbox"/> Birthcentre <input type="checkbox"/> Planned Birthcentre/Hosp. Admiss. <input type="checkbox"/> Planned Homebirth <input type="checkbox"/> Planned Homebirth/Hosp. Admiss. <input type="checkbox"/> Born Before Arrival <input type="checkbox"/>	

PREGNANCY
Has Mother had a Previous Pregnancy Greater than 20 weeks? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, specify Number of Previous Pregnancies > 20 weeks <input type="checkbox"/> <input type="checkbox"/>

THIS PREGNANCY
Maternal Medical Conditions Diabetes Mellitus <input type="checkbox"/> Essential Hypertension <input type="checkbox"/> Hepatitis B+ <input type="checkbox"/>

Obstetric Complications APH—Placenta Praevia <input type="checkbox"/> —Placenta Abruptio <input type="checkbox"/> —Cause Unknown <input type="checkbox"/> Pregnancy Induced Hypertension <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Prolonged Rupture of Membranes (> 24 hours) <input type="checkbox"/> Threatened Premature labour <input type="checkbox"/> Rhesus Isoimmunisation <input type="checkbox"/>

Procedures and Operations Cervical Suture <input type="checkbox"/> C.V.S./Amniocentesis (< 20 weeks) <input type="checkbox"/>

Research Question Was this an assisted conception? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify I.V.F. <input type="checkbox"/> G.I.F.T. <input type="checkbox"/> Other _____
--

LABOUR AND DELIVERY
Labour Spontaneous <input type="checkbox"/> Spontaneous with A.R.M. <input type="checkbox"/> Spontaneous with Oxytocics/Prostaglandins <input type="checkbox"/> No Labour <input type="checkbox"/>
or
Induction Oxytocics/Prostaglandins <input type="checkbox"/> A.R.M. only <input type="checkbox"/> Oxytocics/Prostaglandins & A.R.M. <input type="checkbox"/> Other <input type="checkbox"/>

Presentation Vertex <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>
Other Procedures Epidural Block <input type="checkbox"/> Episiotomy <input type="checkbox"/>
Type of Delivery Normal Vaginal <input type="checkbox"/> Vacuum Extr. <input type="checkbox"/> Forceps <input type="checkbox"/> Vaginal Breech <input type="checkbox"/> Forceps rotation <input type="checkbox"/> Caesarean: —Elective <input type="checkbox"/> —Emergency <input type="checkbox"/>

Complications P.P.H. (600 mls +) <input type="checkbox"/> .3' tear <input type="checkbox"/> Major puerperal infection <input type="checkbox"/> Other (specify) _____
--

Discharge Status	
MOTHER	BABY
Discharged <input type="checkbox"/> Died <input type="checkbox"/> Transferred <input type="checkbox"/>	Discharged <input type="checkbox"/> Stillbirth <input type="checkbox"/> Neonatal Death <input type="checkbox"/> Transferred <input type="checkbox"/> Transferred & Died <input type="checkbox"/>

BABY
Record No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sex M <input type="checkbox"/> F <input type="checkbox"/> Indet. <input type="checkbox"/>
Birthdate <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Plurality Single <input type="checkbox"/> Multiple Birth (Total No.) <input type="checkbox"/> If multiple birth specify Baby No. <input type="checkbox"/>
Birthweight (grams) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Gestation Age (weeks) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Appgr (5 min.) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Resuscitation I.P.P.R. (Bag or Tube) <input type="checkbox"/>

BIRTH DEFECTS
DID THIS BABY HAVE A BIRTH DEFECT? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, specify _____

Neonatal Morbidity (Only if Baby admitted to S.C.N. or N.I.C.U. for 4 hours or more) Yes <input type="checkbox"/> No <input type="checkbox"/>

Date of Death <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date of death <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Baby Transferred to _____	SIGNATURE OF SISTER AT DISCHARGE _____
---------------------------	--

Please use fine tipped ball point pen on hard surface
HOSPITAL COPY