Rhetoric and Reality: Narrowing the Gap in Australian Midwifery

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Certificate of Authorship and Originality

I certify that the work in this thesis has not been previously submitted for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have had in my research work and in the preparation of the thesis itself has been acknowledged. In addition, I certify that all the information sources and literature used are indicated in the thesis.

Signature of Candidate

Nicky Leap

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Table of Contents

Certificate of Authorship and Originality i

Acknowledgements ii

Table of Contents iv

Abstract vii

Prologue viii

Introduction ix

CHAPTER 1 Finding a Framework to Study my Work

FIGURE 1: A Framework for Rhetorical Analysis 21

FIGURE 2: Framework: Rhetoric, Reality and Strategies 25

CHAPTER 2 Midwifery as 'The Cause'

PORTFOLIO TEXT 1: *Journey to Midwifery through Feminism*

FIGURE 3: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 2: *A Vision for New Frontiers*

FIGURE 4: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 3: *Discussion seminar: Masters of Midwifery Students*

FIGURE 5: Framework: Rhetoric, Reality and Strategies

DISCUSSION — Midwifery as 'The Cause'

CHAPTER 3 'A Midwife is a Midwife is a Midwife…'

PORTFOLIO TEXT 4: *Midwifery Entry in Oxford Companion*

FIGURE 6: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 5: *Defining Midwifery Presentation*

FIGURE 7: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 6: *The less we do the more we give*

FIGURE 8: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 7a: *Submission to Nurses Board of SA*

FIGURE 9: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 7b: *Submission to Senate Inquiry*

PORTFOLIO TEXT 8: *Community Midwifery: Conceptual Map*

FIGURE 10: Framework: Rhetoric, Reality and Strategies

DISCUSSION — 'A Midwife is a Midwife is a Midwife…'

CHAPTER 4 Educating Midwives in Australia

PORTFOLIO TEXT 9: *'Direct Entry' Midwifery Courses*

FIGURE 11: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 10A: *AMAP Results: Paper 1*

PORTFOLIO TEXT 10b: *AMAP Results: Paper 2*

PORTFOLIO TEXT 10c: *AMAP Results: Paper 3*

FIGURE 12: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 11: *Monograph: Educating Midwives*

FIGURE 13: Framework: Rhetoric, Reality and Strategies

DISCUSSION — Educating Midwives in Australia

CHAPTER 5 Rhetoric to Reality: Engaging Midwives in Practice Change

PORTFOLIO TEXT 12a: *Resources Matter*

FIGURE 15: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 12b: *To have and to hold*

FIGURE 16: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 13a: *Acting on our language*

PORTFOLIO TEXT 13b: *Words to consider*

PORTFOLIO TEXT 13c: *Crossword puzzle and solution*

FIGURE 17: Framework: Rhetoric, Reality and Strategies

PORTFOLIO TEXT 14: *How can midwifery practice flourish?*

DISCUSSION — Engaging Midwives in Practice Change

CHAPTER 6 Conclusion

Epilogue

Bibliography

APPENDICES

A Permission to include co-authored documents

B *Midwifery according to Aristotle*

C *The Power of Words: Confining Women with Words*

D ACM National Standards

E ACM BMid Information Package

F Graduate Certificate Information Flyer

Abstract:

Rhetoric and Reality: Narrowing the Gap in Australian Midwifery

This study draws on multiple modes of expression in texts that have been generated by my experience of midwifery development since I moved from England to Australia in early 1997. The Professional Doctorate in Midwifery at the University of Technology, Sydney (UTS) has enabled me to produce and study my work as a midwifery practitioner, researcher, educator, writer and activist and to engage in a process of scholarship that both informs and is generated by practice. This has allowed me to analyse the complex issues that I, and other midwives in Australia, face as we strategise to narrow the gap between our ideals and the realities of the professional and political constraints that challenge midwifery. The study analyses the rhetorical communications I have employed as both carriers of 'vision' and 'means of persuasion' and the deliberate strategies to make changes that I believe will benefit childbearing women.

My portfolio challenges me and others, to explore how we are able to identify, enact, and convince others of the emancipatory potential of midwifery. Rhetorical innovations are therefore linked to the exposition of woman centred midwifery care; an overall goal being to enable situations in which women can experience the potential power that transforms lives, through their experiences of childbirth. In the process, I aim to produce new knowledge that will equip midwives to understand practice, policy and political situations and see new possibilities for responding and taking action.

I have analysed and explained my work using a framework appropriated from rhetorical theory and drawing on a range of feminist perspectives. This involves identifying and critiquing the rhetorical innovations that I have used when trying to create possibilities and persuade others of the value of midwifery and the need to make changes happen in practice, education and regulation. My study analyses the rhetorical nature of my own work as presented in my portfolio in a range of carefully selected texts that I have authored during my candidature. These include journal and newsletter articles, conference papers, research activities, policy submissions, education and training materials, the development of midwifery standards, formal and informal communications, and other documents, all aimed in one way or another at the rhetorical strategy of stimulating interest and action. The portfolio texts that arise from this work form the empirical data that is studied. However, in varying ways these texts elicit understandings about the rhetoric and reality of Australian midwifery and the deliberate strategies that are employed by midwives to make changes

that will benefit childbearing women. They therefore stand in their own right as contributions to the thesis with their own discursive and epistemological intent.

The reflexive process employed in this thesis highlights comparisons between what is being positioned as the potential of midwifery with what is also presented as the reality played out in contemporary Australian maternity service provision and in midwifery education and regulation. The thesis weaves its way around the portfolio documents, attempting to bring to life and discuss the culture in which rhetorical innovations and intentional strategies are aimed at narrowing the gap between 'rhetoric and reality'.

Prologue

> Re-vision — the act of looking back, of seeing with fresh eyes, of entering an old text from a new critical direction – is for women more than a chapter in cultural history: it is an act of survival. (Rich, 1977 p.35).

In the feminist tradition of making sense of our worlds through sharing experience and ideas through story telling, I shall begin by explaining briefly the journey that led me to enrol in the Professional Doctorate of Midwifery at the University of Technology, Sydney.

I moved to Australia from England in early 1997 in order to continue to co-parent my youngest child and to start a new life alongside Australian members of my family. I had been coming and going to Australia for twelve years and had a reasonable understanding of the differences in midwifery and the organisation of maternity care in the two countries. I was not hopeful that I would be able to find a place in the Australian midwifery community. For a start, there were serious doubts about whether I would manage to get registered as a 'direct entry' midwife who had never been a nurse. Through the immigration process, the Australian Nursing Council (ANC) had warned me that my qualification was not recognised in Australia, that 'Nurses Boards' in Australia only issued a midwifery practising certificate as an addition to a 'Registered Nurse' (RN) registration. As I shall explain later in this thesis when I discuss the various challenges associated with Australian midwifery's relationship with nursing authorities, the doubts raised by these warnings were not unfounded.

Even if I were to manage to get registered – which I did eventually, ironically as a 'RN restricted to practise midwifery' – I could not envisage how I might practise in Australia. I was mindful that this was a country where approximately one third of pregnant women choose private obstetricians for their care; where midwives in private hospitals and most rural health services do not provide antenatal care and have no opportunity in these settings to do other than 'labour sit' women under 'doctor's orders' and call the medical practitioner to come and 'catch the baby'. I knew that few midwives in the public health service were able to offer continuity of care; that community midwifery and postnatal home visiting were not seen as an essential part of mainstream service provision; and that there were no publicly funded home birth services.

In England, I had been a member of a committed midwifery group practice, the first group of self-employed midwives to 'contract in' to the National Health Service. We were acknowledged in the

ground breaking government document, Changing Childbirth (Department of Health, 1993) as the 'cutting edge' example of what could be achieved in terms of offering disadvantaged women 'choice, control and continuity of care' in a community based midwifery group practice. Whilst working autonomously, providing care for women from booking through to four weeks following birth, we had developed collaborative relationships with obstetricians and midwives in local NHS hospitals as well as with a range of community based practitioners and agencies. Through our policy of 'decision making in labour', over 70% of the women in our care gave birth at home. These were not women who would ever have envisaged the joy of giving birth in the comfort and safety of their own homes. We achieved what some of us in the community of childbirth activism had been working towards for many years. I could not imagine a more fulfilling and purposeful way to work and live my life.

While contemplating moving to Australia, I found the thought of working 'shifts' in a hospital maternity unit depressing. To work independently outside of the health system and charge women for home birth services, in what was often seen as a stereotyped 'alternative life-style' choice for the marginalised few, was also not an option I felt I could happily embrace. I contemplated a career change and had serious intentions to pursue taking my midwifery skills into the comparable world of palliative care and undertaking. As I had discovered when studying midwifery history (Leap & Hunter, 1993; Richardson, 1982), there was a long and noble history of the local midwife, 'the woman you called for' when someone was either being born or dying, 'seeing you in and seeing you out'. It seemed a logical and positive way to go.

Soon after I moved to Australia, a chance meeting at a social gathering changed the course of my life and put paid to any ideas I had of becoming an undertaker. Professor Judith Clare, Dean of Nursing at Flinders University in South Australia had lived through the radical developments in New Zealand midwifery in the previous decade. She had a vision that the School of Nursing at Flinders University could lead the way in bringing people together from across Australia to develop widespread, publicly funded midwifery models of care and a three year Bachelor of Midwifery. She invited me to come to the university and be part of making that happen. She dismissed my protests that I was not an academic and almost convinced me that my view of the potential of an academic career was extremely limited and old fashioned. To my surprise, she was right on both counts. I had always written and spoken at conferences about my work and was not a stranger to teaching and developing midwifery practice. Such activities were an essential part of being a practising midwife engaged in the politics of midwifery in the UK. Through Judith's support I expanded my capacity to teach, write research proposals, submissions and curriculum documents. She pointed me in the direction of working with others to bring together key people from across Australia, in the morale boosting activity of running a conference. The aim was to identify all the innovative midwifery continuity of care models that were already happening. Later, Judith encouraged me to lead a

national collaboration to develop the introduction of Australia's first three-year Bachelor of Midwifery courses.

Thus began my new midwifery life in Australia. This study explores how I have come together with others and incorporated activism in a range of midwifery activities. The portfolio reflects this journey. I trust that I have been able to do justice to the vision, passion, skills and determination of many Australian midwives and colleagues who manage to 'persuade' others of the value of midwifery; who create possibilities and achieve extraordinary changes that would often seem impossible, given the inherent power imbalance of our worlds.

Introduction

> A theme, a thesis, is in most cases little more than a clothes line on which one pegs a string of ideas, quotations, allusions and so on, one's mental undergarments of all shapes and sizes, some possibly fairly new but most rather old and patched; and they dance and sway in the breeze and flap and flutter, or hang limp and lifeless; and some are ordinary enough, and some are of a private and intimate shape. And rather give the owner away, and show up his or her peculiarities. And owing to the invisible clothes line they seem to have some connection and continuity" (Alan Bennett 1994:225. Quoting Kenneth Graham, author of *Wind in the Willows*).

The worlds we study are, to some extent, created by the texts we create to describe or analyse these (Denzin 1996). This study draws on multiple modes of expression, all presented in the form of written texts that have been generated by my experience of midwifery development and activism since I moved from England to Australia in early 1997. The study analyses the rhetorical communications that I have employed as both 'vision' (Hodgson & Knight 2001) and 'means of persuasion' (Herrick, 2001) and the deliberate strategies to enable changes that will benefit childbearing women. I aim to bring alive the complex issues that I, and other midwives in Australia, face as we strategise to narrow the gap between our ideals and the realities of the professional and political constraints that challenge midwifery. I situate myself in this work with a clear recognition of the role that life experiences and values have contributed to my understanding of the politics and practice of midwifery.

Aim of the study

My overall aim in this study is to challenge myself, and others, to explore how we are able to identify, enact, and convince others of the emancipatory potential of midwifery and contribute to changes that put women at the centre of care; this requires changes that enable childbearing women to take the power that potentially transforms lives. In the process I aim to produce new knowledge from which to act, bearing in mind that making sense of our worlds through theory development equips us to understand situations and see possibilities for responding and taking action in those situations (Foss, Foss, & Griffin, 1999; Weedon, 1987).

I have chosen to analyse and explain my work using a framework appropriated from the principles of rhetorical theory as explained by James Herrick (2001). This involves identifying and critiquing the rhetorical innovations that I have used when trying to create possibilities and persuade others of the value of midwifery and the need to make changes happen in practice, education and regulation. My

analysis draws on a range of feminist perspectives. In developing theory that is grounded in practice, I acknowledge that my authority to comment is directly related to my reputation as a practising midwife. The implications of this for developing ways in which 'border dwellers' (Walker, 1995a, 1995b) like myself can find mechanisms to incorporate practice, education, research, writing and activism in our lives, will be a theme in this study, since the components of my portfolio address all of those elements of my work.

Opportunities afforded by the Professional Doctorate in Midwifery

The Professional Doctorate in Midwifery at UTS has enabled me to study and present my work as a midwifery practitioner, researcher, educator, writer and activist and to engage in 'living theory' (Walker, 1995a), a two-way process, noun and verb, that both informs and is generated by practice. The rationale, development, structure and content of the Professional Doctorates in Midwifery and Nursing at UTS have been described by Professor Jill White (1999) in terms of the opportunity to bring together a range of innovative professional activities in a scholarly submission at doctorate level. The study of these activities offers the opportunity for analytical reflection and the development of theory that is grounded in practice and allows for:

> … the potentially rich interplay of the academic tradition of deconstruction and critique, with the pragmatics of the work-world's need to get the job done efficiently and effectively, and the aspirations, practices, codes of conduct and codes of ethics of professional comportment (White, 1999 p.21).

White builds on the work of Boyer (1990) who proposes four layers of scholarship – discovery, integration, application and teaching – and suggests that the outcomes of knowledge acquisition should be described along with 'the process and especially the passion' (Boyer, 1990 p.17). The professional doctorate at UTS – 'unashamedly and overtly politically and culturally critical in its intent' (White, 1999 p.26) – is the perfect vehicle for a study that explores a dynamic, multi-dimensional process of practice development and shifting culture whilst acknowledging the researcher as activist, 'living theory' (Walker, 1995a) within the process and its exposition.

The description of process and the awareness and articulation of the self within that process will contribute to the many threads running through this thesis, as well as the various projects described and identified in the portfolio. This will include studying the 'informal organisation' of the activities, norms, patterns of relationship and communication that arise spontaneously from the effort to organise (Mangham, 1979). An understanding of a particular task or project and an analysis of the overall effectiveness achieved requires insight into the processes by which group members or key players relate to each other, including how they maintain or struggle with cohesion (Napier & Gershenfeld, 1987; Smith et al., 1986). This study aims to incorporate such reflections in its praxis,

integrating an analysis of policy, leadership and international issues as specified by course requirements. By using personal narratives in a variety of texts, I aim to bring to life the culture in which I, and other Australian midwives, feel motivated to make changes that will benefit childbearing women.

Overview of the thesis

As suggested in the title of this thesis, my study examines the rhetorical nature of my work as evidenced in my portfolio by the various texts that I have authored (or in some instances, co-authored). These include journal and newsletter articles, conference papers, research activities, policy submissions, education and training materials, the development of midwifery standards, formal and informal communications, and other documents, all aimed in one way or another to make people 'take notice'. The texts stand in their own right as contributions and also form the empirical data that are analysed throughout this thesis. As such the texts form both substance and subject within the thesis in that they form the subject for the rhetorical analysis. This reflexive process includes highlighting comparisons between what is being presented as the potential of midwifery with what is also presented as the reality that is being played out in Australian maternity service provision and in midwifery education and regulation. The thesis weaves its way around the portfolio documents, attempting to bring to life and discuss the culture in which intentional strategies are aimed at narrowing the gap between 'rhetoric and reality'.

Chapter One documents how I arrived at a theoretical framework for studying my work, drawing on traditional, contemporary and feminist rhetorical theories. A brief history of the history, theories and practices of rhetoric are explored, in particular how feminist perspectives have influenced and challenged thinking about rhetorical studies. Concerns about the potentially problematic notion of 'persuasion' are addressed and the emotional reactions that abound concerning the term 'rhetoric'. I describe how I appropriated principles outlined in James Herrick's (2001) definition of the art of rhetoric - 'the systematic study and intentional practice of effective symbolic expression' (Herrick, 2001 p.7) - in order to develop a framework that illuminates how various texts in the portfolio have been crafted to function with strategic goals and various audiences in mind. I make the case for 'persuasion' and 'strategies' being valid feminist political activities for enabling change, with respect for and consideration of the views of authors who have condemned such concepts as 'acts of violence'. (Gearhart, 1979; Trinh, 1989).

The feminist underpinning, values and potentially problematic nature of specific rhetorical concepts in midwifery are explored in Chapter Two. This includes how I use these concepts in my writing and in different public arenas to further 'The Cause' of midwifery. The analysis draws on my personal experience of midwifery activism and portfolio documents that include conference papers and a book chapter documenting my own journey to midwifery through feminism.

Chapter Three builds on the rhetorical innovations identified in Chapter Two by exploring 'definitions and descriptions of midwifery' as a starting point for political action and the raising of standards. Portfolio texts include a conference paper, book chapter, medical dictionary article and submissions to a government enquiry and a regulatory authority. An analysis of these texts includes examining the cultures in which each text is situated as well as the rhetorical activities and strategies employed to articulate midwifery as a profession in its own right. A commissioned entry - 'Midwifery' - in The Oxford Illustrated Companion to Medicine invites a critique of how midwifery icons from the past and the notion of the midwife as 'wise woman and witch' play a part in the essentialist struggle for collective identity, timeless, universal truths and inspiration. A conceptual map of 'community midwifery as a public health strategy' is analysed for its ability to articulate the advantages of developing a profession that moves away from an acute care model to one that is community based, with a community development and primary health care focus. The struggles of Australian midwifery to develop a separate identity to nursing are also explored in this chapter.

A literature review on Australian midwifery education that was commissioned by a government department as part of a National Review of Australian Nursing Education (Department of Education & Ageing, 2002) informs Chapter Four, which explores education for midwifery practice. The portfolio texts include a trilogy of journal publications reporting on the findings of the Education Survey that I led as part of the Australian Midwifery Action Project (AMAP, 2003)[1]. Publications are also included that reflect the strategies associated with the introduction of a three year Bachelor of Midwifery in Australia. The portfolio texts are arranged to enable an understanding of how evidence from research strengthens persuasive argument. Their chronological publication order allows for an analysis that demonstrates the increasing confidence of the rhetorical innovations I employed. The arguments progress from the opinions and appeals for common sense in a personalised standpoint text to the potent validation of the need for change based on research findings, international compatibility, and the consensus of midwifery leaders from across Australia.

Chapter Five analyses and synthesises various ways in which I have deliberately set out to engage midwives in the rhetoric of midwifery and the processes of making change happen at a personal, practice and professional development level. 'Fun' ways of exploring how language both reflects and constructs culture are explored and various portfolio texts are analysed for the way in which they engage practitioners, release the imagination and enable lively education and practice development.

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[1] The AMAP study was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce; regulation; education; service delivery; and midwifery practice issues across the country.

The conclusion to the thesis revisits and theorises the rhetorical innovation that has been explored and identifies some of the implications for the ongoing development of midwifery in Australia. The case is made for the continuing development of midwifery models of care that are driven by, and reflected in, midwifery rhetoric. This is a rhetoric, I argue, that understands the potential for changes that enable better lives for women and in turn, for their families and communities.

Since 'collective action' and 'bringing people together' are major rhetorical themes throughout this document, much of the work that I am analysing here is work that has been carried out and written with others. I have attempted to make this clear at all stages[2] and trust that the study will pay tribute to the extraordinary achievements that have taken place in Australian midwifery over the last six years due to the efforts of many. The conscious political efforts to develop woman centred midwifery practice and models of care in Australia that enable women to be more powerful in their lives will no doubt continue to be a rich source of feminist rhetorical analysis.

[2] Written permission for the use of co-authored materials in my portfolio has been obtained and can be viewed in Appendix A.

Chapter 1

Finding a Framework to Study my Work

> Feminist rhetorical criticism is activist – it is done not just *about* women, but *for* women – it is designed to improve women's lives. (K. Foss, Foss, & Griffin, 1999 p.5).

> … rhetoric, in both everyday and classical understanding is understood to be a model of communication in which authors and speakers are *consciously* in control of their meaning; in which the individual subject is no longer the unwitting mouthpiece of a discourse or ideology, but its prime mover. (Pearce, 2004 p.6).

I have been involved in 'living theory' — noun and verb (Walker, 1995a, 1995b) — throughout almost twenty five years of being a midwife and before that, during my experiences of being a mother with young children, a youth and community worker, an antenatal teacher and a childbirth activist. In all of this, I have been motivated by my own experience; by the feminist values of the Women's Liberation Movement; and by women's and midwives' narratives of their lives. This has given me an under-standing of the political imperative to speak out and write tales that aim to compel attention and stimulate collective action for social justice and the 'empowerment of groups of interacting individuals' (Christians, Ferre, & Fackler, 1993 pp.193-194). Such considerations inform how I arrange any speaking and writing activity and were no less compelling as I puzzled over how to engage with the Professional Doctorate in Midwifery.

Thesis and portfolio: warp and weft

The process of finding a framework to study my work evolved slowly and was not immediately apparent when I began doctoral study in 1999. I knew that the nature of my personal politics demanded that any analysis of my work would require scrutiny through the multiple lenses of critical feminist perspectives and that ethnographic discourse would play a role in bringing to life the cultures in which I live and practise midwifery. I was also clear that this analysis would be articulated in a thesis that would weave its way around diverse texts that arise from and identify my work, loosely referred to as 'the portfolio'. The notion of 'weaving' is a pleasing concept in writing, not only it because is associated with traditional women's work, but because '*texere*: woven thing' is the Latin root of the word 'text'. Although initially uncertain about the specifics of this structure of warp and weft, I liked Denzin's challenge to create an engaging 'non-linear text with multiple centres' (Denzin, 1996 p.40) in

order to bring to life cultural values and social structures. It seemed to me that the texts in the portfolio might provide 'multiple centres' and that the writing of the thesis around these texts needed to be organised in a way that reflected the multiple layers of contexts in which, and for which, they were crafted. This was certainly not a linear process — many of the texts arose and continue to arise in relation to challenges that continuously overlap, dovetail, recede and rise again to demand attention, during my experience of straddling the intertwined worlds of midwifery practice, research, education and activism.

Since commencing doctoral studies in 1999, my work has involved many projects underpinned by a range of qualitative and quantitative research modes of inquiry, promoting and reflecting on action. Examples include book chapters and journal articles commenting on practice; developing and evaluating midwifery models of care; bringing together midwives to develop national midwifery standards; teaching and curriculum development; workshop and training activities; and research to map midwifery education programmes in Australia. From the start I saw this study as an opportunity to incorporate methods that blur the boundaries of description, critique, and narrative and initially thought that I would be achieving this through what Kim Walker has explored as 'ethno(auto)biography' (Walker, 1995a; 1997). This seemed to be a way to incorporate the responsibility and complex nature of developing theory as a situated knower (Smith, 1989) and participant in the culture that is being unfolded through my study:

> A culture lived and expressed by many is spoken 'of' and 'for' by one who is both written by and writer of that culture. This move simultaneously decentres the authority of the ethnographic data (because it is intensely personal and stained with the values and beliefs of the researcher) while it claims a deliberately ironic (and therefore always unstable and uncertain) privilege to bring to expression the culture of many through the voice of only one. (Walker 1995a: 13)

Seeing fit to comment

In particular, I was mindful of the sensitivities of being a new immigrant - with all the new and old loyalties that such a role brings - who sees fit to comment on a culture and make comparisons that are often uncomfortable. In Australia, there is a particular and utterly understandable, distaste of 'whingeing Poms' that goes way beyond any intellectual analysis of colonisation and irritating English habits in terms of the emotional responses that can be provoked. At times I have been aware of the thin line that exists between the advantages of using rhetoric that 'shames' through international comparisons and the potential hurt that such tactics can cause, leading to resistance and genuine challenges to my authority to comment.

The poem that I originally placed on the 'ozmidwifery' email chat line [see over] suggests some of those sensibilities, as it plays with the notion of the 'introduced alien' and the love of purple in

midwifery and feminist circles. For those who have never seen the stunning purple takeover of the Winter/Spring landscape in the grazing lands of Southern parts of Australia, the poem may need explanation. Layers of controversy surround *Echium plantagineum* beginning with common nomenclature and accounts of how these beautiful purple flowers came to Australia from their Mediterranean origins. Marketed as 'Riverina Bluebell', *Echium plantagineum* can still be found in the wares of certain contemporary florists. However, most Australians know the plant as one of the most prolific 'garden escapes' of recent history. Some will tell you that 'Patterson's Curse' was introduced to grace the garden of the Patterson's Albury home, escaping to cause havoc across the surrounding, newly created, grazing meadows. Others will dwell on this plant's other popular name, 'Salvation Jane' and will tell tales of desperate efforts by pioneers to feed their cattle as they opened up the bush land for European farming efforts. Their plans backfired as toxins contained in the 'rampant weed' poisoned cattle and sheep and presumably, though not discussed, any native fauna who survived the destruction of their habitat.

Today, few will disagree that the 33 million hectares occupied by *Echium plantagineum*, at an estimated annual cost to the agricultural industry of $250 million, pose a challenge. Efforts to eradicate the 'Purple Peril' (the name bestowed by the Adelaide Hills Council) through public awareness campaigns and virus carrying beetles are half heartedly challenged by bee keepers, for whom *Echium plantagineum* is an important source of pollen, and scientists in Sydney, who have discovered that the seeds contain 40% Omega 3 oils and 25% Omega 6 fatty acids, found elsewhere only in fish. The potential for metaphor and allegory is profound!

I originally posted the 'Purple Poem' on the ozmidwifery email chat line. Later the Tasmanian branch of the Australian College of Midwives reproduced it in their newsletter. It is published here as it appeared there because it was irresistible to include the juxtaposition of the poem alongside the 'Letters' section on the same page. One letter from '43 and a Full Time Student' honours the support of 'caring and positive people'. I wonder if these are the same midwives as the 'group of Germaine Greer lookalikes' identified in the other letter by 'Name withheld' who 'finally' has to write to question 'what all the feminist commentary has to do with midwifery'. *Echium plantagineum* and the politics of midwifery – A[wo]men!

Echium plantagineum: 'Salvation Jane' or 'Patterson's Curse'

Reproduced here with kind permission from photographer, Rob Hartill.

From: *Midwifery News and Views: Newsletter of the Tasmanian Branch of the Australian College of Midwives* Spring 1999. p.2

Just a thought… *Reprinted from* ***ozmidwifery*** *by kind permission of the author, Nicky Leap, Senior Research Fellow, Flinders University of South Australia.*

A Purple Poem

Between manicured vineyards
small patchwork gasps
of purple splendour
in defiance of policy
left to titillate tourists?
Purple Peril!
say roadside notice boards
Council admonishments
to rid us of this noxious weed

Salvation Jane
or Patterson's Curse?
sobering reminders
of desperate survival measures
introduced aliens
introducing aliens
plundering a stolen landscape

Purple Peril indeed!
strident images forming
layers of contradictory metaphor
chosen colour of suffragettes
of midwives, bishops and ageing women
purple for passion
perpetuating purple prose
ignore at your peril

And yes -
as I grow old I wear purple
and investigate purple possibilities
purple flashing lights
atop the purple plastered cars
of midwives on call.

McLaren Vale, South Australia – September 1999

Letters

Dear Editor
I would like to thank all the midwives who responded so positively to me about the article '43 and a Full Time Student'. One midwife told me it almost inspired her to start studying. Well, that was the idea (without the almost). I feel honoured to be counted among such a caring and positive people. For those who were inspired, please don't hesitate to call on me. I'd love to be able to return the support that so many of you have given me.

43 and a Full Time Student.

Dear Editor
I feel I must finally write to say I'm not sure what all the feminist commentary has to do with midwifery. Where are the other opinions that many midwives might have that don't make it into these pages? Is the Tasmanian College being taken over by a group of Germaine Greer lookalikes?
When will you publish something with a different opinion?
Not being critical, just wondering?

Name withheld.

Ed comment: Just as soon as anyone puts something forward. We don't knock anything back, so get writing.

How to engage with meaningful critique?

As I settled into my new identity as 'an Australian midwife, originally from the UK', I grappled with how my doctoral study would take shape. I was hoping to find a way to identify how my personal values and beliefs are played out in my work whilst writing a thesis that would resonate with midwives; also that this work would, at least, form a useful platform for discussion and further political action. The tyranny, as well as the exhilaration, of putting together a professional doctorate is that it enables those who are 'doers' to continue to amass pieces of work for inclusion in the portfolio at the expense of stopping the 'doing' and analysing the process as well as the activity. So it was that the portfolio kept growing and, like Jack contemplating the proverbial beanstalk, I continued to scratch my head about how to engage with this unleashed and unwieldy productivity in terms of meaningful critique. I began to search for a specific framework that would allow some thematic organisation to an approach that uses the personal narratives of 'ethno (auto) biography' and critical feminist critique. I was not sure whether I was struggling with contradictory concepts that had no chance of marrying. As Robbie Pfeufer Kahn (1995 p.14) identifies, the value of personal storytelling is that it creates conditions for knowing that engage the heart and mind in a fluid process that moves beyond the particular; however, this approach may be at odds with the use of overarching theories that can restrict and leave work 'fastened by stakes, like a circus tent in one small spot'. To use a phrase from the West of England where I grew up, I wanted 'my bun and my ha'penny' in this search for a way of organizing my thesis that would allow for reflexivity that does not curb the creativity of storytelling.

Initially, I thought my thesis would be called, 'Defining midwifery as we develop woman centred practice'. As the potential texts for inclusion in the portfolio grew, I began to think that 'defining midwifery' was only one aspect of the political nature of my work reflected in those texts. In 2001, I discovered a book by Mary Lay (2000), entitled, *The Rhetoric of Midwifery: Gender, Knowledge and Power*. Lay analyses the evidence of traditional or 'direct entry' midwives, professional midwives, nurses and obstetricians in public hearings to determine whether or not midwifery should be legalised in Minnesota. She uses this opportunity to offer a rhetorical study of midwifery and the conflicting discourses of those who gave evidence. Lay draws on two definitions of 'rhetoric' that reached out to me, in terms of possibilities for my own thesis. The first is Aristotle's explanation that rhetorical analysis is 'the faculty of observing in any given case, the available means of persuasion' (Bizzell & Herzberg, 1990 p.153). This classification is simplified by McCloskey (1985 p.29) to 'the study of how people persuade'. The reason these definitions struck a chord with me, is that every aspect of my work seems to revolve around trying to 'persuade' people – midwives, maternity service users, obstetricians, nurses, educators, other health workers, policy makers, regulatory authorities, the 'nursing' union, childbirth activists, interested observers and others – of the actual and potential

value of midwifery. This element of 'persuasion' can be seen in all of the texts in my portfolio. I started reading about 'the art of rhetoric' with the enthusiasm of one who has had, what Australians refer to as 'An Aha! Moment'.

Discovering rhetorical enquiry

I was far from disappointed with this new field of enquiry as the initial resonance I experienced concerning the notion of 'persuasion' led to an understanding of how rhetorical analysis might be the catalyst for explaining and critiquing my work. I developed a theoretical framework to analyse each of the texts in my portfolio adapted from James Herrick's (2001) definitive book, *The History and Theory of Rhetoric: an introduction*. Herrick defines the art of rhetoric as '… the systematic study and intentional practice of effective symbolic expression' (p.7) and his explanations of the distinguishing features of rhetorical discourse formed an ideal base from which to design the theoretical framework for the analysis of my work. In fact, my writing became the data now opened to scrutiny and analysis informed by this perspective. Once this was accomplished, it became clear to me that it would be useful to make comparisons between what is identified in rhetorical discourse as the potential of midwifery and the reality that exists in Australian midwifery practice, education and regulation. Conveniently, I found myself writing and speaking of these realities as simultaneously, I engaged with others in two major areas of work: research activities to 'map' Australian midwifery[1] and the process of developing national standards for midwifery[2]. These activities were undertaken with a frank political and overt agenda for change in mind. It became obvious that the efforts to 'narrow the gap' between the rhetoric and the 'realities' of Australian midwifery could be seen as the deliberate strategies employed by all those engaged in midwifery development and childbirth activism. Thus, the title of this thesis materialised; I felt relieved, ready to 'climb the beanstalk' and clear about how to settle into the exciting task of analysing my portfolio.

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[1] The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce, regulation, education, practice and service delivery issues across the country.

[2] The Australian College of Midwives (ACMI) Bachelor of Midwifery Taskforce, a representative group of experts from across Australia was set up with an aim to develop national standards for the introduction of the three-year Bachelor of Midwifery in Australia. It has subsequently developed a wider role in developing standards and position statements as The Australian College of Midwives National Education and Standards Taskforce. My role in convening these groups will be discussed in Chapter 4.

Perspectives and the art of rhetoric

I have decided not to give an overview of the history of the art of rhetoric here, although I found there was much to be enjoyed from studying its long and distinguished history dating back to classical Greece and Rome, in particular the work of the grandfather of rhetoric, Aristotle, who had much to say about many things, including midwifery (See Appendix B). An exploration of the relationship of rhetoric to power, knowledge, ethics and the building of human societies offers an opportunity to identify unifying concerns across time and cultures. As identified by Lynne Pearce (2004), the taxonomies of classical rhetoric can be employed to make visible the features of contemporary composition and thought production. A focus on rhetorical strategy allows for a degree of 'choice, experiment and conscious control' whilst ensuring that 'text and context, author and audience [are] forever in view (Pearce, 2004 p.6).

In their analysis of contemporary rhetoric, Sonia Foss and colleagues (S K Foss, Foss & Trapp, 2002) identify that identify that minor changes in the central characteristics of the study of rhetoric are less important than changing perspectives brought to bear on this method of enquiry. They suggest that 'perspectives' is a more useful concept than 'theory' when applied to rhetorical studies. Whereas a theory implies a coherent body of knowledge that attempts to organise explain and predict some aspect of the world, the term 'perspective' suggests both an organised and coherent body of knowledge as well as one that is less organised in its viewing and interpretation of a phenomenon through a set of conceptual lenses.

Contemporary perspectives on rhetoric tend to view the art as the unique human ability to use symbols in order to communicate with one another (S. K. Foss et al., 2002) This definition has come to be used in all formats and contexts (including the private realm) about any humanly created symbols from which audiences derive meanings and interact to construct shared understandings of the world; therefore it is argued that any communication medium can be included in a definition of rhetoric (S. K. Foss et al., 2002). In contemporary rhetorical studies, 'communication' and 'rhetoric' are often seen as synonymous but Foss et al (2002) identify that scholars trained in the social-scientific areas of speech communication may prefer the term 'communication', while those who employ more qualitative methods of inquiry, or whose work is rooted in the humanities and philosophy, tend to select the term 'rhetoric'.

The motivation to conceptualise rhetoric as the study of symbols used in communication has been described by many contemporary authors as a means of shifting the emphasis of rhetorical enquiry away from the notion of 'persuasion':

> More recent definitions have broadened the scope of rhetoric to include any kind of symbol use – verbal, visual, formal, informal, completed or emergent – and even the intentional and persuasive aspects of early conceptualisation of rhetoric have come to be questioned. Although still viewed traditionally by some rhetorical theorists, rhetoric usually is seen now as incorporating virtually any humanly created symbols from which audiences derive meanings. (K. Foss et al., 1999 p.6).

Whilst embracing the creative potential of such loose definitions of rhetoric, I was aware that it was the notion of 'persuasion' that had captivated my initial interest. The challenge was therefore to address the ethics of this aspect of my own practice activism and reflexivity.

'The pervasiveness of persuasiveness'

The notion of 'persuasion' is at the heart of common suspicions about rhetoric as an immoral activity ending in deception and manipulation. The phrases, 'empty rhetoric' and 'It's only rhetoric' are commonplace and we have become used to politicians, in particular, discrediting or dismissing each other's policies and ideas as 'just rhetoric'. Herrick (2001) acknowledges that it is not surprising that people are suspicious of persuasion, given that any of us can think of bad experiences where we have been the object of another's persuasive efforts. However, he suggests that we are 'perpetual persuaders' in our personal and working relationships on an almost daily basis and that it is hard to conceive of any human relationship or organisation that does not depend on efforts to change thoughts and actions:

> … though our experiences may leave us leery of persuasion, persuasion is also an important component of our occupational, social and private lives… To recognise what we might call "the pervasiveness of persuasiveness" is not to condemn persuasion or rhetoric. Rather, it is to begin to appreciate the centrality of this activity to much of life, and to recognise that human beings are rhetorical beings (Herrick, 2001 p.3).

Herrick's justification of persuasion is offered in part to address the challenges to rhetoric posed by post-modern scholars. In recent decades, the intellectual movement that emerged from Europe and the United States stimulated a renewed interest in persuasive discourse and the strategies by which individuals and groups achieve power. Scholars such as Ferdinand de Saussure, Claude Levi-Strauss, Michel Foucault, Jacques Derrida and Jacques Lacan explored the relationships between language, culture, knowledge and power as critical social and cultural theory. A post-modern critique of rhetoric begins with challenging its roots in Ancient Greece where it was seen as the art of leading the human soul towards 'truth'. The honouring of multiplicity to disrupt hegemonic thought and practice (Trinh, 1989) is at odds with such reductionist notions as persuading people of any one 'truth' or set of 'truths'.

Rhetorical enquiry: feminist perspectives

> Feminist rhetoricians have worked diligently to make clear to the academic world and to the public generally that women must be afforded a rhetorical voice, and that women's rhetoric will not resemble the male-constructed rhetoric we have received form our intellectual fathers. Their work has opened up a vast field of rhetorical analysis of discourse by and for socially oppressed groups. The influence of the feminist critique has been, and will continue to be, profound (Herrick, 2001 p.265).

The traditional notion of rhetoric that is associated with efforts to discern 'truth[s]' in some discernable and verifiable fashion has given way to perspectives that privilege interaction in order to reach a shared understanding of the world. Inevitably such processes raise questions about whose construction of reality is privileged in a culture and whether such realities are always socially constructed through symbolic interaction. (K. Foss et al., 1999; S K Foss, Foss, & Trapp, 2002; S K Foss & Griffin, 1995). The traditional site of rhetoric in the public sphere - debate, law, religion and public ceremony - has shifted from the domain of mostly famous white men to the private realm. Feminists have played a major role in this shift through identifying those who lack access to the political arena, in particular, women and marginalised groups (K. Foss et al., 1999; S. K. Foss et al., 2002; Herrick, 2001; Trinh, 1989).

Trinh T. Minh Ha (1989) was one of a number of feminist scholars to criticise traditional rhetorical practices, at the same time pointing out how recent discourse by male scholars, such as those mentioned above, presents problems for women. In 1989, Karen and Sonia Foss made explicit the invisibility of women and women's experience in the work of men who shaped Western rhetoric in the second half of the twentieth century. They pointed out that women have been denied a voice in culture because their discourse is excluded from the public realm. Women's perceptions, experiences, meanings, practices and values are not incorporated into language (K. Foss & Foss, 1989). In the 1980s, an increasing number of women began to articulate how the loss of women's meanings in rhetorical discourse results in the loss of women themselves as members of the social world (K. Foss & Foss, 1989; S. K. Foss et al., 2002; Spender, 1985).

The importance of bringing feminist perspectives to bear on rhetoric is articulated by Karen Foss and colleagues (1999), as a way of viewing every facet of life. Feminism for these authors presents possibilities for different ways of living in the world. It is rooted in choice and self-determination and can incorporate many definitions and perspectives as it evolves in different contexts. However, they suggest that feminism arises from a commitment to enacting a set of principles that:

- validate the values and experiences often associated with women.
- give voice to individuals marginalised and devalued by the dominant culture
- establish and legitimise a value system that 'privileges mutuality, respect, caring, power-with, interconnection, and immanent value… values that stand in direct

> contrast to those that characterize the dominant culture – hierarchy, competition, domination, alienation, and power-over for example.' (Summarised from K. Foss et al., 1999 p.5).

Through disclosure of their personal life experiences, these authors describe how they struggled to find the connection between Aristotelian and other classical theories and women's rhetorical activities. By bringing feminism into rhetoric they claim to have developed a useful and positive way of sharing symbols from which people can derive meaning:

> We define rhetoric as any kind of human symbol use that functions in any realm – public, private, and anything in-between…Our goal… is no longer to learn how to persuade others; rather it is to understand how people construct the worlds in which they live and how those worlds make sense to them. (K. Foss et al., 1999 p.7).

According to Karen Foss and colleagues (1999 p.14) five dimensions or threads have contributed in significant ways to the development of feminist perspectives in rhetorical studies:

- Radical beginnings
- Efforts to include women as communicators and women's topics in the discipline
- Critiques of the discipline from feminist perspectives
- Labelling and refining of feminist perspectives
- Reconceptualizations of constructs and theories in rhetorical studies from feminist perspectives. (Summarised from K. Foss et al., 1999 pp.14-15).

The authors identify that these dimensions do not represent linear progression, nor are the categories necessarily distinguishable from each other. They continue to overlap contribute to research that expands knowledge. The study of rhetoric is important because we are surrounded by symbols and need to be conscious of how these function and how they influence our lives (K. Foss et al., 1999). Furthermore, rhetoric is valuable because it can and does create reality, and therefore it is an important way in which individuals create their worlds, perspectives and identities:

> In almost any situation, innumerable options exist for how to act and respond. Understanding how rhetoric functions allows us to make conscious choices about the kinds of worlds we want to create, who and how we want to be in these worlds, and the values we want these worlds to embody. The study of rhetoric, then, enables us to understand and articulate the various ways individuals create and enact the worlds in which they choose to live (K. Foss et al., 1999).

Feminist rhetorical theory offers a way to frame experiences and events, to organise, describe, name and explain phenomena in our worlds. Since all individuals can theorise, there are multiple opportunities for the development of theory, including perspectives that are contradictory and diverse (K. Foss et al., 1999). Personal journeys in the world of theorising are directly related to the development of feminist consciousness and the conceptualisation of rhetoric (Thompson, 2004).

By organising the particulars of our individual lived experiences and ideas in relation to rhetorical analysis, we move to larger patterns and attempt to make sense of our experiences and ultimately, our lives. This process mirrors the consciousness raising of the women's Liberation movement of the 1970s and 1980s; it is driven by a deliberate attempt to promote understanding, which better equips and motivates us towards action through systematic and coherent responses.

Karen Foss and colleagues (1999) are keen to identify what they call 'transformations' that might occur as a result of feminist perspectives on rhetoric. They define 'transformation as 'the process of expanding a familiar construct – changing its composition, structure or function – in order to enable it to accommodate or explain new material.' (K. Foss et al., 1999 p.12). They suggest that transformation occurs in two ways: through new approaches to a construct through a different standpoint or ideological frame, or through the use of new data that stimulates new conceptualisation, in particular, through the process of identifying and shifting the power dynamics associated with language use. (K. Foss et al., 1999).

Throughout this thesis, concern with language plays a major role. In Appendix C, I place a publication that I wrote many years ago: *The power of words and the confinement of women* (Leap, 1992). I include it because it demonstrates my early alertness to and understanding of the importance of language in midwifery practice (Hewison, 1993, 1996; Kirkham, 1989) and because it is a reference point that I return to throughout the portfolio. Long before I had the advantage of studying the theory of how language both reflects and constructs language (Denzin, 1996; Luke, 1996; Spender, 1985), I was aware of how this is played out in midwifery practice. This will be explored more fully in Chapter Five. I am raising this here because this understanding of language plays a role in how I began to conceptualise 'persuasion' and developed the 'strategies' explored in this thesis.

Some feminist authors see any form of persuasion as 'an act of violence' (K. Foss et al., 1999 p.16). For example, Sally Miller Gearhart (1979) rejects the notion of persuasion because she sees it as violating the audience's integrity through exploitation and objectification. The alternative that she proposes is concerned with creating 'atmospheres' or environments in which change can occur through a process of mutual reciprocity. As explained by Foss et al (1999) in collaboration with Gearhart, her approach appears to be limited to one-to-one connections through private relationships of trust and respect, rather than attempts to influence others or create change in the public sphere. Such an approach presumes that an audience is not capable of sifting or rejecting persuasion, that any rhetor renders an audience passive, and that audiences are naïve and uninformed. Assumptions are made that rhetors do not view their audiences as experts in their own right and that there is no room for the testing of ideas; the re-distribution of power; relationship

building; and nurturing of communities – issues, or indeed, values, at the heart of how I approach this study.

Sonja Foss and Cindy Griffin (1995) offer a less damming approach to rhetoric than Gearhart (1979) in what they conceptualise as 'invitational rhetoric - [an approach] that does not require or assume intent to persuade on the part of the source' (S. Foss & Griffin, 1995). The 'invitation' to an audience is to 'enter the rhetor's world and see it as the rhetor does' (S. Foss & Griffin, 1995). Change may be the result of invitational rhetoric, but change is not the primary focus of the rhetor's purpose. The authors do not want to assume that members of the audience are not content with their belief systems, or that they do not function well within them. They propose:

> … an invitation to understanding as a means to create a relationship rooted in equality, immanent value, and self determination. (S. Foss & Griffin, 1995 p.5).

I can understand how this approach might work in one-to-one or small group interactions amongst those who start their interactions from a position that allows and addresses the imperative to create equal, emancipatory relationships. I am however, cautious about how invitational rhetoric can function in a world of indoctrinated hegemony and hierarchical structures. Often in the midwifery politics of activism and practice development, a more overtly challenging approach to shifting the power in relationships and systems is required for emancipatory change. In contemplating practicalities, I find myself musing on how often persuasion plays a core role in this imperative and am unable to eliminate it from my view of how midwifery is played out in my life at every level.

In developing the invitational approach to rhetoric further, K. Foss et al (1999) invite the use of the word 'options' as an alternative to 'strategies', which is a word associated with 'combative, goal directed, ends oriented efforts at persuasion' (K. Foss et al., 1999 p.12). The 'options' suggested by these feminist rhetors tend to revolve around challenging and changing patriarchal culture through changing language. Whilst recognising and demonstrating that this as an important symbolic action, one which continues to play a part in how midwives engage with their worlds, I will continue to use the word 'strategy' in this thesis. A practice based profession engages with so-called 'symbolic interaction' (K. Foss et al., 1999) to affect change on many levels besides re-designing and challenging language. The word 'option' does not speak to me of action in the way that 'strategy' does; it does not encompass the notion of deliberate political acts aimed at considered outcomes in the world of midwifery practice. I suggest that goals are not necessarily counter-productive to developing a feminist way of being in the world and I trust that my feminist sisters will join with me in re-claiming and re-conceptualising the word 'strategy', relieving it of its military connotations, and transforming it into a new construct that serves to find new emancipatory possibilities.

When collaborating with Karen and Sonja Foss and Cindy Griffin over their exploration of feminist rhetorical theories, Trinh T. Minh-ha paints a picture of how she sees rhetorical analysis that is not dissimilar to this thesis: a process of trying to find patterns or sets of ideas, values and beliefs that are 'superior' due to their transformative potential, their grounds for argument or their ability to be inclusive of multiple perspectives (K. Foss et al., 1999). Trinh suggests that this is a flawed process since any ideology is deeply suspect; no one ideology can be better than another simply because of the values it embodies. Trinh believes that all ideologies and strategies are oppositional and 'tainted by their desire to rigidify, categorize, and stabilize, and thus ought to be challenged' (K. Foss et al., 1999 p.248). A process of constant questioning and disruption is suggested instead, with uncertainty as the central tenet of an approach that aims to unsettle the hegemonic nature of the world, including the stable self. I take this challenge very seriously and see it as being at the centre of the tension that exists in my work and in the wider world in which midwives practise. On the one hand, midwifery philosophy embraces uncertainty, multiplicity, diversity and reflexivity; on the other hand, there is a yearning amongst midwives for universality that crosses cultures and strengthens a sense of community and activism. However, I see the process of constant unsettling suggested by Trinh (1989) as potentially counter-productive to the process of coming together around common concerns to build and enact solidarity and an emancipatory vision. Such dilemmas will be explored throughout this thesis.

Rhetorical enquiry: ethical considerations

Herrick (2001) suggests that condemnations of 'persuasion' remind us to strive to identify and develop standards that reflect the ethical obligations and moral restraints in which rhetoric should be practised. Rhetoric brings a measure of power to those who practise its art, particularly in regard to the potential influence of the rhetor on an audience. The rhetor is often in a position to decide who has a voice and what may be spoken of, to whom, in any given situation. According to Herrick (2001) an understanding of such power relationships can contribute to the art of rhetoric playing a major role in re-distributing power. In any discourse regarding midwifery, issues of power and ethics are always simmering under the surface, if not blatantly exposed. I trust that by acknowledging the persuasive elements of my work, I will have an opportunity to address these issues in a relatively structured way. This will include a deliberately self-conscious attempt to take seriously the challenge that persuasion is always an act of violence.

My thesis is deliberately written around elements of persuasion and strategies that will improve maternity services for childbearing women in Australia. In light of the criticisms discussed previously, one of the challenges for me is to demonstrate how the strategies and 'means of

persuasion' analysed in this thesis can be seen as a series of political actions that are self consciously feminist in their intent and have multiple ways of being enacted.

A framework to analyse my work

> A theory of writing is also a theory of interpretive (ethnographic) work. Theory, writing and ethnography are inseparable material practices. Together they create the conditions that locate the social inside the text. Hence those who write culture also write theory. Also those who write theory, write culture. (Denzin, 1996 p.xii).

I have developed a framework for studying my work that is based on Herrick's identification of the components of rhetorical discourse. In summary, any rhetorical innovation is

- planned
- adapted to an audience
- shaped by human motives
- responsive to a situation
- persuasion seeking
- performs a social function. (Summarised from Herrick, 2001).

In terms of this thesis, such conceptual categorisations allow me to employ reflexivity in studying a broad range of work portrayed as portfolio texts, drawing on both classical and recent methods of rhetorical interpretation. For each portfolio text explored, this framework will provide a method of analysing work that I have been involved in. I have chosen texts to present here in my portfolio from a range of my written and spoken work including research, education, journal articles, newsletters, conference papers, national standards, submissions to government enquiries and regulatory boards, curriculum development, practice development, and teaching and workshop activities. The chosen portfolio texts form the empirical data that is studied. In varying ways these texts elicit understandings about the rhetoric and reality of Australian midwifery and the deliberate strategies that are employed by midwives to make changes that will benefit childbearing women. They therefore stand in their own right as contributions to the thesis with their own discursive and epistemological intent.

A summary of the questions that I will address and explore, in relation to each of the six components of rhetorical discourse, is presented in Figure 1 below. These questions will guide my analysis of the empirical data.

Figure 1: A Framework for Rhetorical Analysis – Adapted from Herrick JA (2001) *The History and Theory of Rhetoric: an introduction.*

Rhetoric is planned

- Which arguments and evidence will I advance and how will I arrange these?
- What aesthetic resources are available to me, given my topic and audience?

Rhetoric is adapted to an audience

- Who are my audience and do we have values, beliefs, experiences, aspirations, social status and knowledge in common?
- If not, how do I attend to theirs, forge links between theirs and mine and promote their welfare?
- What might they accept as true, probable or desirable?

Rhetoric is shaped by human motives

- Who invited me and what are the commitments and motives of the audience?
- What are my commitments, goals, desires, purposes here? What actions do I want?
- What symbolic resources will draw people together and promote action?
- Are my motives elusive, clearly evident, hidden or explicit?

Rhetoric is responsive

- Is this a response to a situation – a particular time, location, problem, audience – and/or to a previous rhetorical statement?
- How does this invite responses and what might these be?
- What are the opposing views, constraints, and circumstantial factors including my abilities?

Rhetoric seeks persuasion

- What are the symbol systems employed here?
- What resources am I drawing on: argument, appeals, arrangements and aesthetics?

Social functions of rhetoric

- How does this test ideas, strengthen arguments, enable refinement?
- How might the audience determine the quality of the rhetoric?
- How is this assisting advocacy?
- How is this connected to power distribution: personal, psychological and political?
- Whose ideas have a voice and what kind of language is permissible?
- How does this discover and draw on facts/evidence - for decision making?
- How does this shape knowledge?
- How does this build and nurture a sense of community?

Addressing 'realities' through rhetorical discourse

> Rhetorical discourse… obtain[s] its character-as-rhetorical from the situation which generates it… Rhetoric is a mode of altering reality …by the creation of discourse, which changes reality through the mediation of thought and action (Bitzer, 1968 p.3).

Almost as soon as I decided to study my work through rhetorical enquiry, the commonly used rhetorical phrase, 'Rhetoric and Reality' kept presenting itself as a concept that demanded attention. It seemed obvious to me that any rhetorical conceptualisation of midwifery is responding to a set of circumstances that are less than optimal in terms of how midwives are able to practise and offer a service that has benefits for women, their families and communities. The motivation for employing rhetoric cannot be discussed without an analysis of the context and culture that supports, but more often, inhibits midwifery. The identification of these factors is a starting point for developing 'strategies' or 'actions' to address the limitations and constrictions within which midwifery is practised. An understanding of this was particularly evident in the core research questions of the afore-mentioned AMAP study, which engaged midwives in exploring the 'barriers' and 'strategies' to effective midwifery in Australia. Identifying barriers in order to mount strategies to overcome these barriers is also a workshop technique that I employ on a regular basis with midwives when working with them on developing their practice.

Once again, the work of Herrick (2001) provided me with an understanding of how rhetorical theory addresses these issues. Herrick (2001) identifies that rhetorical discourse is responsive to a situation: 'it is crafted in response to a set of circumstances, including a particular time, location, problem and audience'. (Herrick, 2001 p.11). According to Herrick, Lloyd Bitzer's 1968 essay, 'The Rhetorical Situation', is regarded as a turning point in the study of rhetorical theory in terms of how it explains rhetoric as situational. Bitzer (1968) argued that three elements define a rhetorical situation:

Exigence: '…an imperfection marked by its urgency: it is a defect, an obstacle, something waiting to be done, a thing which is other than it should be' (p.6).

The Audience: '… properly speaking, a rhetorical audience consists only of those persons who are capable of being influenced by discourse and of being mediators of change (p.8).

Constraints: '…every rhetorical situation contains a set of constraints made up of persons, events, objects and relations which are parts of the situation because they have the power to constrain decision and action needed to modify the exigence (p.8).

In terms of the 'reality' aspect of the catch phrase 'Rhetoric and Reality', chosen as a title for this thesis, it is important to make it clear that I am addressing 'reality' as a way of representing 'the rhetorical situation'. I understand that for many readers, the word 'reality' is problematic in terms of its suggestions of fixed 'truths' and that 'reality' is defined by the subjectivity of both the writer of texts and those who read them. However, I have planned the texts studied here in a culture where the very mention of 'rhetoric' tends to evoke an oppositional sense of ideology versus 'the real world'. The midwifery rhetoric that I, and others, employ arises in direct response to 'constraints' and 'imperfection[s] marked by… urgency' (Bitzer 1968: 6). As such, the texts are deliberately self-conscious around issues related to power and control.

In this thesis, 'reality' is therefore taken to mean the 'situation' that is addressed by midwifery rhetoric in any given text. This 'situation' is described by reference to literature that identifies the culture of Australian midwifery; by my own observations; and by research findings that identify the various constraints that affect and construct midwifery practice, education and regulation. In particular, I will present the findings of empirical research that I led, which elicits information regarding the state of midwifery education in Australia (Chapter 4).

'Narrowing the gap': strategies for action

Identifying the gap between what is proposed in midwifery rhetoric and the situation faced by Australian midwives is the platform from which action is proposed, hence the second part of the title of this thesis. As Herrick (2001) identifies, rhetoric is usually intended to influence an audience to accept ideas from which they can act in a manner consistent with those ideas. Sometimes this involves a testing and refining of ideas through rhetorical discourse and the invitation to respond.

Often the rhetorical innovations employed in the portfolio texts are the strategies. For example, the rhetoric of 'coming together' is a deliberate strategy to create opportunities for midwives to share ideas and information in order to take action and make changes at an individual or collective level. Similarly, the rhetorical exposition of how 'woman centred care' can be linked to 'evidence based practice' is in itself the proposal of a strategy.

The process of using rhetoric to enable a community - in this case, midwives – to come to agreements about what they know or value is one of the critical social roles employed by rhetors (Herrick, 2001). Rhetoric allows a testing of ideas that is epistemic and the purpose of many of the texts explored here is to develop knowledge from which to act. Importantly, a sense of community is engendered by this process, one that facilitates collective action. Thus there is an overlapping and

inter-connectedness of rhetoric, situation [reality] and strategy, which will become evident as each of the portfolio texts is analysed.

Organisation of the thesis

In order to identify the specific rhetorical concepts employed in any given portfolio text as well as an overview of the 'realities' being addressed and the strategies that arise from the work, the Framework for Rhetorical Analysis was adapted further. Figure 2 shows the Template Framework: 'Rhetoric, 'Reality' and Strategies' [referred to hereafter as 'the Framework']. Three additional columns alongside an abbreviated version of the original Framework for Rhetorical Analysis provide an, 'at a glance', view of the issues that are discussed in relation to individual portfolio texts. The structure of the framework is arranged as follows:

Column 1 sets out the principles of rhetorical discourse

Column 2 looks at the deliberate planning and intent of the text. It identifies consideration of the audience and the situation concerned when employing arguments, evidence and aesthetics. This column also shows how the text is responsive to the motives of both rhetor and audience.

Column 3 identifies the rhetorical concepts that are employed

Column 4 shows the 'realities'[3] of the situation that are uncovered

Column 5 lists the strategies that are suggested as a means to address the 'realities' and affect change through action[4].

Thus, this Framework helps to show how the rhetorical analysis of each text is linked to the title of the study: 'Rhetoric and Reality: Narrowing the Gap in Australian Midwifery'. I trust that the Framework itself - as well as the individual texts and ensuing discussion - will contribute to, as well as generate, new knowledge from which to act.

Each chapter in the thesis will begin with an introduction to the theme that will be explored in the chapter. The portfolio texts that have been chosen to reflect the chapter's theme will be listed. Each of these texts will be presented followed by a synthesis in the form of the Framework described above. The texts will then be subjected to rhetorical analysis and discussion.

[3] 'Realities' in this context means the authors view of the challenges that face Australian midwives in terms of any situation that does not reflect the rhetoric that is proposed as the 'ideal'

[4] It is worth noting that the rhetoric employed in any text and the identification of realities that need attention can also be seen as deliberate 'strategies' in their own right.

Chapter 2

Midwifery as 'The Cause'

> If we could survive the wretched lot of the student midwife, we could qualify and provide a service that would aim to enable women to feel powerful through their experience of childbirth. Implicit was the understanding that we would talk, write and campaign about the 'why' and 'how' of every aspect of creating changes for childbearing women. We referred to this process as 'The Cause'[1] since this was the colloquial term we employed (with tongue-in-cheek irony) to describe the embodied concept of feminist midwifery activism that became the focus of our lives. (N Leap, 2004a p.186).

In this chapter I will study some of the commonly used rhetoric of midwifery, in particular how I use these concepts in my writing and in different public arenas to further 'The Cause' as described above. This will include addressing the careful planning of these documents and the potentially problematic nature of some of the rhetoric that I use.

This chapter draws on three portfolio texts:

Portfolio Text 1:

A book chapter: Journey to Midwifery through Feminism: a personal account. In M. Stewart (Ed). 2004. *Pregnancy, Birth and Maternity Care: Feminist Perspectives.* Chapter 13. London: Books for Midwives Press. pp. 185-200.

Portfolio Text 2:

PowerPoint slide for a conference paper: *Rhetoric and Reality: a vision for new frontiers in midwifery education in Australia.* Plenary address to the Australian College of Midwives 5th Biennial Conference in Darwin, September 2003.

Portfolio Text 3:

PowerPoint slides for a discussion seminar with Masters of Midwifery students in Christchurch, New Zealand, April 2003. *Midwifery Knowledge: rhetoric and reality.*

I have chosen these three texts to present and analyse here because, although they were planned with different audiences in mind, each of them addresses the most commonly used rhetorical concepts in midwifery and makes an appeal for midwives to come together to make change happen.

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[1] Cause: what produces an effect: person or thing that occasions something; reason or motive; justification; side in a struggle, principle etc. to further that for which people strive; united efforts for a purpose (Australian Pocket Oxford Dictionary 1985)

Portfolio Text 1

Book Chapter

Journey to Midwifery through Feminism: a personal account. In M. Stewart (Ed). 2004. *Pregnancy, Birth and Maternity Care: Feminist Perspectives.* Chapter 13. London: Books for Midwives Press. pp. 185-200

Portfolio Text 2

PowerPoint slides for a conference paper.

Rhetoric and Reality: a vision for new frontiers in midwifery education in Australia.

Portfolio Text 3

Discussion seminar with Masters of Midwifery Students, Christchurch and Dunedin, New Zealand April 2003. *Midwifery Knowledge: Rhetoric and Reality*.

Discussion:

Midwifery as 'The Cause'

> Emergence is the surprising capacity we discover only when we join together (Wheatley & Kellner-Rogers, 1996 p.67).

The portfolio texts for this chapter were chosen because they are all examples of rhetorical discourse that seeks persuasion whilst testing ideas and nurturing a sense of community in the name of 'The Cause'[2]:

> … the group's symbols, metaphors, and ways of reasoning function to create a common bond that promotes a strong sense of community despite physical separation. Moreover, communities are sustained over time by the rhetorical interaction of their members with one another and with members of other groups (Herrick, 2001 p.23).

Each text employs the resources of symbol systems that have been recognised throughout the centuries as assisting the goal of persuasion. Herrick (2001 p.13) summarises these symbols systems as: arguments, appeals, arrangements and aesthetics. Herrick's definition of these resources is useful to bear in mind when considering the planning and delivery of each of these texts:

> *Argument*: reasoning made public with the goal of influencing an audience
> *Appeals*: symbolic strategies that aim either to elicit an emotion or to engage the audience's loyalties or commitments
> *Arrangement*: the planned ordering of a message to achieve the greatest effect, whether of persuasion, clarity or beauty
> *Aesthetics*: elements adding form, beauty, and force to symbolic expression
> (Summarised from Herrick, 2001 pp.13-14)

An understanding of how these symbols systems are employed needs also to consider elements of power in terms of how they are used. Here this means being aware of the personal power that I might have in being able to shape and influence the thinking of others. It also means exploring the function of using rhetoric in order to address inequalities and distribute power at a personal and political level. In midwifery, this includes an examination of the barriers to effective midwifery, within a common understanding that 'effective' midwifery has the potential to facilitate situations where childbearing women are able to feel and be more powerful in their lives. This can be seen as core business of 'The Cause' and it is articulated through the rhetorical promotion of 'woman centred care' in personal and political spheres. Each text discussed here focuses on 'woman centred care' as well as a range of other issues that are central to the rhetoric of midwifery.

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[2] As identified in the book chapter discussed here, 'The Cause' is '… the colloquial term we employed (with tongue-in-cheek irony) to describe the embodied concept of feminist midwifery activism…'

The changing face of 'coming together' in midwifery

The original use of the phrase 'The Cause' by midwives implied more than a support group of like-minded souls. Embedded in the concept was a suggestion that the group's sense of community and shared understanding would lead to collective action in order to improve a situation, in this case, the lives of childbearing women. 'Collective action' is a notion that encompasses a broad range of empirical phenomena where groups have mutual interests and can see possible benefits from coordinated action (Marwell & Oliver, 1993). Rhetorical discourse plays an important role in the social construction of meaning that stimulates collective action and as Klandermans (Klandermans, 1992 p.82) points out, collective action in turn determines the construction of meaning. This circular process underpins the rhetorical intent of the texts that will be analysed in this chapter.

Echoes of the politics of midwifery that arose from the Women' Liberation Movement of the 1970s and 1980s are evident in the texts explored here and can still be identified in contemporary midwifery rhetoric (Downe, 2004; Guilliland & Pairman, 1995; Kirkham, 2000; Stewart, 2004). However, the links to activism are no longer immediate or even generally articulated. Certainly the ideology of working for social change and justice is not apparent in most midwifery circles. The socialist 'culture of responding – seeing a problem and feeling obliged to do something about it' — identified by Andrews (Andrews, 1991 p.164) in her study of elderly activists, is rarely a compelling theme of midwifery literature. This is noticeable even in the newsletter of the Association of Radical Midwives, which used to be renowned for such rhetorical positioning. No longer is a sense of midwifery identity articulated as the 'being' and 'doing' of purposeful, directed political activism and group activity described by Andrews (1991 p.64). I am aware that this is the root of my own motivation but increasingly, midwives are motivated to come together by other experiences and values.

In keeping with health care policies in the Western world, midwifery politics have shifted away from a socialist stance where demands are made for governments to focus on inequalities in health and the responsibilities of a welfare state. Feminist principles are more likely to be understood in terms of the neo-liberal individualistic concepts of 'choice, control and continuity of care' (Department of Health, 1993; NHMRC, 1996) rather than any attempts to transform social structures, social divisions and the unequal control of resources. It is increasingly hard to organise mass rallies of childbirth activists (personal communications Maternity Coalition). This is likely to be due to the shift in rhetorical positioning towards demands for 'one-to-one' midwifery care. This rhetoric potentially feeds into the apathy of 'me' culture and individualistic principles. The focus is on individual women's needs rather than outrage at systems and structures that increase the privilege-disadvantage gaps in maternity care.

An awareness of these issues is important when analysing the proposed strategies to narrow the gap between the rhetorical positioning of midwifery and the perceived restrictions the profession faces at every level, as identified in the chosen texts for this chapter. The major theme of 'coming together' is argued in terms of a common aim to support each other in order to make changes. Midwives are encouraged to come together to break down hierarchies; to share ideas and information; and to think and act with a sense of community and unity. The collective writing of proposals and standards and the examination of potential changes in systems and individual practice have replaced rallies and protests as the major focus of collective action.

The rhetoric of 'coming together'

An underlying assumption of a common sense of purpose is expressed in all three of the portfolio texts; there is a supposition that the audience will have a commitment to 'The Cause'. Obviously this is not necessarily so, but the purpose of articulating the assumption is that the situations and rhetoric explored may, at least, be evocative and therefore encourage the audience to see possibilities for change and transformation. This approach is synonymous with the notion of communitarian ethics and participatory politics where the common goal is to 'establish forms of communal solidarity and friendship that honour demands for justice, moral respect and reciprocal care' (Denzin, 1996 p.279). As identified by Kelly and Breinlinger (1996), people are motivated to engage in collective action where a sense of efficacy, common purpose and approval by important others is engendered.

Coming together to strengthen "the College"

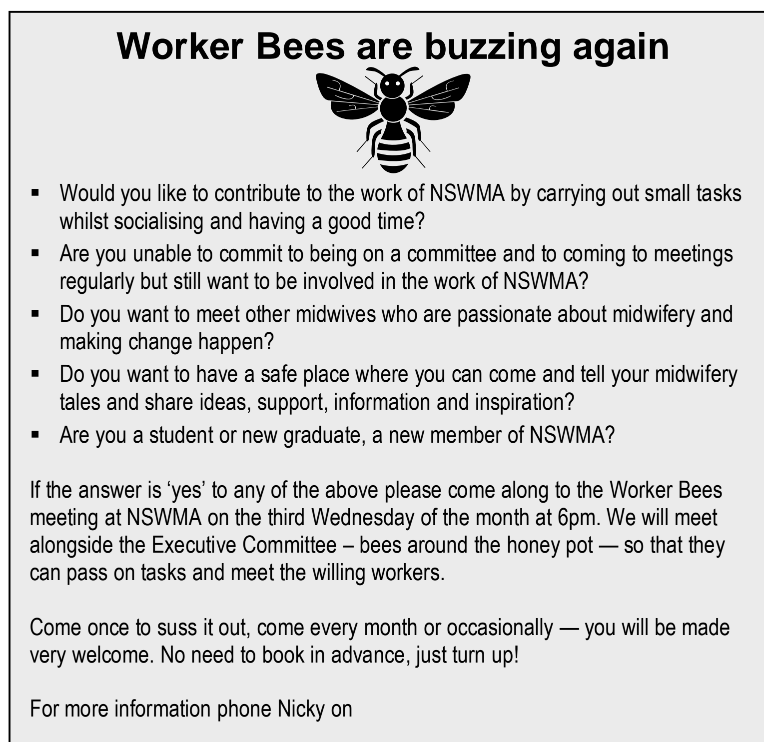
The important components of coming together that are described in the portfolio texts can be summarised thus:

- Knowing the group would be there once a month
- Members participate from every level of the midwifery hierarchy found in maternity services
- Sharing the same politics about changing the culture of childbirth and the need to support each other
- Sharing ideas, stories, skills, information
- Engendering solidarity to enable action
- Getting the work done.

Attempts to re-create structures that enable such coming together are employed in my everyday working life and in efforts to strengthen the activities of the Australian College of Midwives (ACMI). With an income arising only from membership fees and fundraising activities, the ACMI is unable to function as a union or to provide legal or industrial relations services to members. Motivation to join the ACMI is therefore composed of altruistic midwives who are passionate about raising standards and developing midwifery in Australia: midwives who willingly engage in 'The Cause'. The average age of midwives in Australia is 47 and rising (Tracy, Barclay, & Brodie, 2000). There is a need to attract and involve new midwives as outlined here in an article I wrote for *Midwifery Matters,* the newsletter of the New South Wales Midwives Association, the NSW branch of the ACMI:

> Last year I found myself contemplating (again) the fact that so much work is done for our College by so few, most of us well over the average age of midwives. When talking to midwives, in particular students and new graduates, I was aware that many see College work as something that experienced 'leaders' do and not as something that they would volunteer for or necessarily see themselves as contributing to. For many midwives, being a midwife is in itself a huge political commitment and efforts to make change happen in the workplace are demanding enough without taking on macro-level tasks and the commitment of meetings.

I returned to the inspiration of my experiences in the UK as a member of the Association of Radical Midwives in devising a similar support group that embodies all the rhetorical concepts of 'coming together' that are outlined above. The 'Worker Bees' group is a strategy that aims to offer the positive components of engaging midwives in support and activism, as the following advertisement in *Midwifery Matters* demonstrates:



The 'Worker Bees' meetings follow feminist process (Wheeler & Chin 1991). As modelled in the running of open antenatal and postnatal groups (Leap, 2000), members have a chance to introduce themselves and then tell a story about something that has happened at work (or at home) in the past month. Discussion of common fate and criticism of legitimacy are the mechanisms that have always underpinned consciousness raising (Kelly & Breinlinger, 1996). There is the potential to break down the concept of hierarchy that 'places power in the hands of a few over the many' (Rowland & Klein, 1997 p.14) through consciousness raising that leads to collective action. According to Bunch (1983), the essence of this coming together is the development of theory that both grows out of and guides action in a 'continuing spiraling process' that can be divided into four interrelated parts:

- Describing what exists and the naming of reality
- An analysis of why the reality exists and the origins of women's oppression
- Strategies concerning how to change that reality
- Determining a vision for the future (Summarised from Bunch, 1983 p.251)

The rhetoric of coming together for support, to break down hierarchies, and to share ideas and information is evident in this short article in the national ACMI newsletter with it's clear persuasive intent to broadcast the concept of 'Worker Bees' as a strategy to strengthen 'The College':

The NSW Midwives Association has been running a group called 'Worker Bees' for over 12 months. We think it is a concept that attracts members to become more involved with college activities and would like to share the idea with other ACMI branches so that they can consider introducing it in their state or territory.

We advertise in each Branch newsletter and through our informal networks we invite any member (or even non-member) to become involved in the Association by coming to monthly meetings in the office in Sydney.

> The NSWMA Executive meets on the same night in a separate room. Everyone takes a break halfway through the evening to have dinner together (supplied by the Association). This enables the Worker Bees and the Executive to socialise with each other and is particularly welcoming for new members.
>
> Each Worker Bee session starts with a round of introductions and everyone is invited to tell a story about anything that has happened in the last month. This is usually something significant at work, but it might also be something at home – the Worker Bees form good friendships. The group is not hierarchical – students and new graduates mix with experienced midwives and people can choose to come as often as they like. There is no pressure to make a regular commitment.

> After the round, the Worker Bees carry on chatting while they undertake tasks given to them by the Executive (although usually it is actually the Admin Officer who coordinates what they need to do and always a list of tasks is ready). Jobs at this stage are usually fairly simple such as compiling education packages, or putting invoices or receipts into envelopes, but the intention is to broaden this to include tasks such as developing strategies to improve the profile of the organisation.
>
> The Worker Bees idea offers an informal gathering for peer and professional support and information sharing. It relieves the pressure on the Executive in terms of tasks and is an ideal way for members to contribute to the college if they do not have the time or confidence to commit to regular meetings.
>
> ('Worker Bees abuzz' *Midwifery News*. Summer 2004. p.35)

The style of this text is deliberately designed to appeal to midwives who would not necessarily become involved in collective action. As with any rhetorical innovation, consideration of the audience in mind has informed the way the text is written.

Planning with an audience in mind

All three portfolio texts in this chapter aim to test ideas and develop theory from which to act. The processes of planning and preparation involved in each case reinforce consideration of the concepts explored by Chaim Pereleman and Lucy Olbrechts-Tyteca in their groundbreaking work (Perelman & Olbrechts-Tyteca, 1951, 1969) regarding the theory of audience. These authors suggested that the capacity of an audience to engage with a rhetor defines the quality and significance of theory that can be generated. Any planning begins with what Pereleman and Olbrechts-Tyteca call 'the starting points' of argument which can be divided into 'the real: facts, truths and presumptions' and 'the preferable: values, hierarchies and lines of arguments related to the preferable' (Perelman & Olbrechts-Tyteca, 1951). Discourse is thus adapted to and affected by its audience.

The starting point for formulating any rhetorical discourse is the self as audience. Pereleman and Olbrechts-Tyteca maintain that this is the most pure form of preparation of arguments, since it is untainted by any efforts to employ tactics of persuasion. They suggest that an audience of one person should be the next step in preparation. This person can work intensively with the rhetor to check all steps in argumentation before ideas are tested in the universal sphere to see if they transcend local and personal biases (Perelman & Olbrechts-Tyteca, 1969). This strategy made sense to me at a personal level since it is my routine practice to ask a colleague to engage with my work before publishing or speaking at a conference. This is also a strategy that I advocate to students as an important testing of ideas in situations where we feel 'safe' to explore ideas and uncertainty.

The individual planning of each of the three portfolio texts began with consideration of the audience and the particular contexts of the audiences' worlds. An outline of each is presented here followed by a brief overview of some of the rhetorical concepts that are found in all three texts and how these relate to engaging midwives in 'The Cause'.

Planning: Rhetoric that describes a personal journey

> … I hope that aspects of my story and perceptions will resonate with others in the ongoing process of making changes in midwifery practice that put women at the centre of care: changes that enable women to take the power that potentially transforms lives (Leap, 2004 p.186).

The book chapter makes very clear its intent to give a personal account of how I believe feminism is played out in 'woman centred' midwifery practice. In focusing on knowledge gained through and of experience it is unashamedly ontological in its approach. The writing both assumes, and makes explicit, shared values and goals that place women at the centre of care and enable them to take power through the experience of childbirth. There are deliberate efforts to engage the reader in processes such as reflection; story telling; coming together; support; exploring uncertainty; and collective action. The text is thus saturated in rhetorical concepts. These are outlined in Figure 3 and will be explored further throughout the thesis.

The technique of using a personal journey as a reflexive tool allows for an exploration of what Faye Thompson describes as 'a distinctive midwifery ethic implicitly available in the lived realities and shared engagement of midwives and mothers' (Thompson, 2004 p.xii). In the portfolio text, there is an attempt to use my story as a means for examining the exercise of power within the midwifery relationship, which is made explicit throughout the text. The final text box suggests 'questions for reflection' that aim to move the reader beyond my own story into an exploration of similarities and differences in their own lives; in effect these cues test the resonance and thus the rhetorical purpose of the book chapter:

Questions for Reflection

- What issues in my background motivate me as a midwife to change things: my identity/character, social beliefs, politics, life events…
- How do I employ 'rhetorical means of persuasion' in my midwifery life?
- How are power dynamics played out in my working life and at home? Are there similarities?
- What relevance do books like *The Female Eunuch* (Germaine Greer) have for women's lives today?
- Who are the role models/mentors who have inspired me as a midwife?

The technique of using textual graphics such as this text box has become an intrinsic component of the communication of knowledge in contemporary texts Pearce (2004). The potential for graphics to position points in a way that is encapsulated within a visual 'short-cut' to understanding is an important technique when communicating ideas. Thus, design has become an essential component of the conceptualisation of book chapters such as the one analysed here.

It would be possible to view the book chapter chosen for analysis as a feminist 'standpoint text' (Denzin, 1996 p.53) since it is an interpretive epistemology grounded in my lived experience, a text that works outwards from my identities in the private sphere towards my identities in the public arena of midwifery (Clough, 1994). The book chapter moves through the radical feminist tradition of seeing the 'personal as political' in the telling of a 'journey', to suggestions of the wider context and culture in which midwifery is practised, and further still to the potentially transformative effects of birth on women's lives. This is an approach that blurs the distinctions between private and public spheres and attempts what Smith has called a discourse situated in the 'everyday/everynight world' (Smith, 1989 p.34) of actual lived experience. As Smith identifies, such an approach does not aim to simply reproduce the lived experiences of women; rather it is a mechanism to show how women's actual experiences relate to ruling orders and structures, and to bring value to knowledge that is often suppressed in existing epistemologies in the social sciences.

The expected readership of the book for which the book chapter was written includes students and academics as well as practising midwives and childbirth activists who are keen readers of midwifery texts arising from Western countries. I am mindful of the responsibility of engaging in a standpoint text that potentially imposes my own values on the reader and found this book chapter very hard to write. There is a constant tension to avoid uncomfortably forceful polemic when writing and speaking the often passionately felt rhetoric of midwifery. This anxiety is reflected in the rather tentative expression of my concerns that my narrative might be seen as self-indulgent or too subjective to be of any interest. What is hinted at, with reference to the editor's encouragement to write my story, is a suggestion that my public profile as a midwife who writes and speaks out on a regular basis is a factor for stimulating the interest of an audience. However, I am careful to identify an understanding that is 'steeped in my subjectivity as a white, middle-class woman involved in the politics of the women's liberation movement in the 1970s and 1980s in London'. There is reference to the limitations of this personal starting point when considering the politics of economic and cultural oppression.

According to Berrey (2003), any discourse that arises from life history should adopt a hermeneutic perspective:

> … a person's biases are the ontological necessary beginning point for understanding historicality and from which one always questions versions of 'reality'. Biases are a person's way of belonging to groups, culture, society and of grasping meaning of situations from a given perspective, which cannot be eliminated from the self. (Berrey 2003 p.105)

The biases identified in the portfolio chapter are presented as feminist principles. What is not made explicit though is that any descriptions of a personal genesis from the Women's Liberation Movement ideology underpinning the book chapter will be steeped in what is classified as 'radical feminism'. I was attempting to draw on examples of my own life experiences that challenge a traditional view of politics as an external function, unrelated to women's lives. I was also arguing for a way of viewing midwifery that concentrates attention on the empowerment of individual women, rather than according them political power in the broader sense. There is always a danger that such an approach universalises women's experience (hooks 1984) and midwifery rhetoric is particularly vulnerable to this challenge. This is an area for discussion that I will return to later in this thesis.

The acknowledgement of the limitations of one person's account when bringing to life the multiplicity of midwives' experiences is followed in the book chapter by an expression of hope that aspects of my story and perceptions would resonate for others 'in the ongoing process of making changes in midwifery practice that put women at the centre of care.' This is a rhetorical strategy to engage the audience through identification around a common goal. As Roman (1992) explains, an emancipatory principle underpins any approach aimed at engaging groups in collective and democratic theorising about commonalities and differences in their experiences.

Throughout the portfolio book chapter there are relatively gentle invitations, triggered by personal stories, to consider the gendered experiences of being a midwife, linking these to the experiences of women in childbirth and in turn, to the wider issues of the oppression of women in society. I have deliberately tried to share ideas and experiences in a way that would be accessible and easy to read (Bell & Klein, 1997; hooks, 2000) as I was aware that for many midwives making the link between 'woman-centred care' and feminism would be a challenge. As bell hooks (2000) describes in her extremely accessible book *Feminism is for Everyone*, there is a need to counteract the stereotypes associated with the word 'feminism', the fear and the fantasies – 'man haters… angry women who want to be like men' – in words that are not thick with 'hard to understand jargon and academic language' but in texts that are 'straightforward, clear… easy to read without being simplistic'. (hooks, 2000 p.viii). Like bell hooks (2000), I was eager to share my ideas about feminism in a way that would 'let the movement into everyone's mind and heart' (hooks, 2000 p.x) whilst being mindful of the bombardment of conditioning that works against the hope offered by the feminist movement. The explanations about why I see feminism and primary health care principles as

integral to how midwifery should be practised are therefore explained in as straightforward a way as I could fathom, mustering examples from my experience that I hoped would make sense to those who are unfamiliar with such concepts.

Tribute is paid throughout the portfolio book chapter to those who have influenced my thinking. This is not merely about honouring those who have become icons for many midwives. It is part of the process of moving outwards from the personal to the wider context and to the familiar (Clough, 1994). The reader has more than simply my reflections to draw on in considering the movements and people who have shaped contemporary midwifery ideology; a sense of a common philosophy is suggested that aims to strengthen the claims I am making. Similarly, my stories of giving birth and becoming a midwife are deliberate attempts to bring to life the culture and social structures in which these experiences take place, with the minimum of effort on the part of the reader. Denzin describes producing texts that allow the reader to 'imaginatively feel their way into the experiences that are being described' (Denzin, 1996 p.12). Since midwifery is almost exclusively a female profession, and since the majority of midwives in the Western world work in hospitals where they daily confront the hegemony of obstetrics and horizontal violence from colleagues, the potential to write a text that resonates is relatively straightforward. These 'realities' are described and implied throughout the portfolio book chapter and form the focus addressed by the strategies for resistance and change.

Planning the book chapter: arrangement and aesthetics

I have arranged the portfolio book chapter using techniques aimed at engaging the reader in 'The Cause' through the use of aesthetics. Clear headings are deliberately positive, using 'up beat' words such as 'inspiration', and 'motivation', and there is a calculated attempt to be transparent in reclaiming rhetorical concepts such as 'woman centred care', 'midwifery as a public health strategy', and 'feminism and the rhetoric of empowerment'. The quotations at the start of each section are chosen for their particular aesthetic value; they hope to startle the reader into looking and thinking further. Interestingly, the aspect of the book chapter that I get most comment on, often from complete strangers, is the start of the section, 'the motivation of giving birth' where I describe my emotions after giving birth myself for the first time. This has given me courage to include personal stories in my writing and see these as a form of epistemology and motivation.

Planning the conference paper

A starting point for analysing the portfolio conference paper is consideration of the authority that has been invested in me and that gives me a voice in the community I am addressing. I was invited

to give this paper in a plenary session at the Australian College of Midwives (ACMI) 5th Biennial Conference in Darwin. In terms of ascertaining that there was no doubt in the minds of the conference organizers regarding what I would be talking about, it is useful to know that this invitation was offered following peer review of the following Abstract:

RHETORIC AND REALITY:
A VISION FOR NEW FRONTIERS IN MIDWIFERY EDUCATION IN AUSTRALIA

This paper explores a vision for new frontiers in midwifery education in Australia. The rhetoric of midwifery education identifies that we should be enabling a practitioner who 'hits the ground running' on Day 1 of qualification, someone who can 'hang up her shingle', as a 'practitioner in her own right' capable of 'autonomous midwifery practice,' 'crossing the interface of community and acute services', working in 'woman centred' midwifery group practices' 'in partnership with women' offering them 'continuity of carer'. The Australian Midwifery Action Project (AMAP) Education Survey highlighted various challenges to such notions in terms of the gap between our aspirations and the reality of what we can currently offer to midwifery students and new graduates. Milestones such as the introduction of the three year Bachelor of Midwifery and four year double degrees in Nursing and Midwifery may address the workforce crisis in midwifery but such initiatives force us to consider the standards we wish to set in our programmes. In articulating a vision for the future, the author argues that understanding the realities of the barriers we face and forming clear strategies for overcoming them is a good starting point. We need to move beyond concentrating on the limitations of the present system to enabling collective action for change at every level that will support midwifery education and new models of care.

I could be confident that midwives attending this conference would be motivated and that, on the whole, we would share common values and goals in relation to midwifery. In contrast to the Royal College of Midwives in the UK, which has over 35,000 members and acts as a powerful trade union for its members, the ACMI has 3,000 members out of an Australian midwifery population estimated to be approximately 13,800.[3] Members receive little other than a journal, a newsletter and the privilege of belonging to a professional organisation that strives to set standards and make its voice heard in a system where its education, regulation and trade union are controlled by nursing institutions (AMAP, 2003; Brodie, 2002). There was every chance that the audience would have at least heard of the Australian Midwifery Action Project (AMAP) Education Survey findings (see Chapter 4) at previous local and national conferences, or read about the concerns raised by the

[3] As identified by Brodie & Barclay (2001), the precise numbers of practising midwives is unknown since each state and territory has different methods of collecting data and registering midwives. Since all midwives have to register as nurses, in some instances this means that people who have acquired a midwifery practising certificate at some stage continue to identify themselves as midwives on annual registration even though they are engaged in nursing and no longer practise midwifery.

research in the ACMI press. This paper's intention was to move everyone on from the 'doom and 'gloom' of the realities that had recently been exposed by the research, and engender a sense of vision and purpose. In terms of rhetorical analysis, this means that the paper was planned with this audience and action in mind; it was responsive to a situation that demanded attention; it was shaped by the motives of both myself and the audience with the social functions of testing ideas, using evidence for decision making and nurturing a sense of community (Herrick, 2001).

The portfolio conference paper starts by making a bid to 're-claim' rhetoric as a strategy for change, as a means of 'enacting a passion for midwifery possibilities' through 'collective action' and a 'vision for midwifery education and practice'. This language is deliberately rhetorical in its intent. Feminist and other emancipatory political groups use the notion of 're-claiming' language as an empowering strategy to undermine patriarchal domination and the colonisation of language. Examples include the 'Women re-claim the night' marches and the deliberately provocative language of 'queer' politics. I was aware that the idea of re-claiming rhetoric as a 'means of persuasion' was likely to appeal to midwives, in the same way that it had appealed to me when I discovered it. Midwives who are politically motivated to change systems are constantly in situations where they are trying to 'persuade' others of the value of midwifery in order to achieve 'health gain' and improve the lives of women: central tenets of 'The Cause'.

The conference paper links a sense of vision to the work of the ACMI in developing standards for the future of midwifery education, an area of activity that will be addressed in a subsequent chapter. The conference in Darwin gave me an opportunity to elaborate on how the draft ACMI Philosophy will filter through all standards that are developed in order to ensure that midwifery practice and education is 'woman centred'. These concepts are explored in depth in the next chapter.

The logical next place to go in this paper was to acknowledge the difficulties of making change happen in a 'fragmented, hierarchical' system 'borrowed from the army and adapted for nursing' (Flint, 1988; 1993 p.25), a culture of 'medical dominance, horizontal violence, power and control' that stifles woman centred care. This recognition of the 'reality' midwives face in their day-to-day life in terms of issues pertaining to power and control is an important rhetorical strategy. Any rhetor articulating a vision needs to convince the audience that they are not speaking from an impractical academic world of idealism that bears no relation to 'the real world'. The strategies suggested to 'change the culture' are therefore a mixture of practical and philosophical considerations, grounded in practice, but nevertheless, aimed at stimulating the imagination, raising possibilities and promoting action.

Planning the conference paper: arrangement and aesthetics

Throughout this presentation, PowerPoint images are used for aesthetic effect. The title page has a padlock and the key down the side of each slide is finally made explicit: 'We hold the key'. Whenever a new concept is introduced, a pin figure points to the stars. The paper ends with a sense of urgency reinforced by the image of a contorted signpost with arrows heading in different directions. A picture of dinosaurs enhances the story of a haunting conversation I had with radio-journalist Julie McCrossin, who suggested:

> You midwives will always be there. There will always be some women who want to have pain and do the Mother Earth thing. But my prediction is that you'll become like the bijoux health food store option with most women going to the supermarket for their elective epidural and their elective Caesarian section… (personal correspondence with Julie McCrossin 2003)

Questioning whether we are 'dinosaurs' in our approach, questioning whether there will be midwives for our daughters, our nieces, our grandchildren (and finishing with a slide of my own grand daughter) are rhetorical strategies that cross the fine line between rhetoric and polemic. The intent is a 'wake up call' to guard against complacency and to promote action through coming together in 'The Cause'.

Planning the discussion with Masters of Midwifery students

The PowerPoint slides that guided the invited discussion with Masters of Midwifery students in New Zealand offer an opportunity to present a brief overview of the main rhetorical concepts found throughout my work. Since I had worked with these Masters students in a seminar in the previous year, I knew that they would be keen to grapple with challenging issues and that we shared similar values and ideologies concerning midwifery. I therefore prepared for an in-depth discussion of the potentially problematic nature of the main rhetorical concepts that are used in 'The Cause', namely:

- Woman Centred Care
- Midwives are Guardians of the Normal
- Informed Choice
- Evidence based practice
- 'The less we do the more we give'[4].

All of the Masters students were engaged in midwifery practice, either as Lead Maternity Care (LMC) providers or as employees of hospitals and I was aware that they were motivated to engage

[4] These notions are explored fully elsewhere in this thesis.

in a reflexive process firmly grounded in their day-to-day midwifery practice. My aim was to guide them through exploring some of the 'sacred cows', the essential notions of midwifery rhetoric that are often taken for granted. I was open to learning from the discussion – the slides were merely a starting point – and to some extent, this was an opportunity to engage in the rhetorical goal of testing and strengthening ideas. It was also an opportunity to explore how midwifery rhetoric is played out in different cultures and to build a sense of community around our common aspirations, philosophies and perceptions.

I was not to be disappointed. The slide show analysed here in no way pays tribute to the discussion that it triggered which was wide ranging and thought provoking. As in any gathering of midwives in Western countries, we spent a lot of time discussing issues of power and control: how midwifery practice can remain 'woman centred in a culture that constantly grapples with medical dominance, horizontal violence and fragmented, hierarchical systems.

The Cause: Woman Centred Care

A central tenet of 'The Cause' is the development and exploration of how 'woman centred care' is enacted in midwifery practice. A short definition of 'woman centred care is offered as a starting point for discussion in each portfolio text analysed in this chapter. Originally, I wrote this definition for the regulatory authority in New South Wales, who were using the phrase in their documents, but were unable to find a definition. I wrote it and modified it through a process of putting it in front of colleagues for critique and made changes until there was consensus that it answered common challenges, such as, "What about fathers/the baby/ the woman's family?"[5] Although it can be found in the portfolio texts, it is reproduced here in order to demonstrate how eventually it was incorporated into a national philosophy for the Australian College of Midwives through a process of collective action (see next page):

[5] It is interesting to note that comparable documents in the USA have chosen 'family centred' rather than 'woman centred' as a core tenet of practice. In Australia, many would feel more comfortable with 'family centred' as inclusive nomenclature. The rationale for explaining 'woman centred' as a concept is therefore often challenged in debates with health practitioners and university colleagues.

Woman Centred Care: a Definition

Woman centred care is a concept. It implies that midwifery:

- focuses on the woman's individual needs, expectations and aspirations, rather than the needs of the institution or professionals
- recognises the need for women to have choice, control and continuity of care from a known caregiver or caregivers
- encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself
- follows the woman across the interface of community and acute settings
- addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations
- recognises the woman's expertise in decision making

Nicky Leap (prepared in 2003)

As identified in the portfolio book chapter, feminist principles are evident in each of the points in this definition. Strategies to shape and change midwifery practice are also embedded in the definition so that the locus of control is shifted away from the institution towards the woman within her community.

One of the potential problems of a 'woman centred' approach is that it subtly shifts the focus of attention away from political challenges to the social structures in which 'woman centredness' is played out (Gatens 1994). Rosalind Coward (1989) offers similar challenges to the notion in her important exploration of the 'alternative health' movement. Concentration on the individual can be interpreted as sitting within a neo-liberal paradigm that offers little opportunity to transform social structures through collective action. These issues were debated and addressed whilst developing the *Australian College of Midwives (ACMI) Philosophy Statement* (2003) , a document to underpin standards for midwifery practice in Australia. The process of developing such documents through consensus decision making is addressed in Chapter Four but the ACMI *Philosophy Statement* is included here since it demonstrates the development of a more overtly political definition of woman centred care that addresses the need for political action and moves beyond concentration on the individual woman.

Australian College of Midwives Incorporated
Philosophy Statement[6]

Midwife means 'with woman'. This meaning shapes midwifery's philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society.

Midwifery is a woman centred, political, primary health care discipline founded on the relationships between women and their midwives. Midwifery:

- focuses on a woman's health needs, her expectations and aspirations
- encompasses the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the woman herself
- is holistic in its approach and recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself
- recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers
- recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals
- is informed by scientific evidence, by collective and individual experience and by intuition
- aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems; the focus is on the woman, not on the institutions or the professionals involved
- includes collaboration and consultation between health professionals.

My discussion with the Masters students in New Zealand included exploring connotations associated with the word 'care'. There is the potential for the word to conjure up gendered images of altruism, self-sacrifice and the traditional nursing/patient dynamic where the one who 'cares' has power over the one who is cared for and women's agency is located in others (Hoagland, 1991). Challenges to the notion of power sharing in the midwifery relationship are not unusual in the New Zealand context (Flemming, 1998, 2000; Surtees, 1998). The students were comfortable with the concept of woman centredness, but in the New Zealand setting - a society founded on the notion of 'partnerships' – the focus of midwifery practice is more likely to be 'the partnership model' identified by midwifery leaders, Karen Guilliland and Sally Pairman (Guilliland & Pairman, 1995). Either way, there is an assumed feminist ethic underpinning the concept of placing the midwifery

[6] We have drawn on the work and ideas of national and international leaders in midwifery and documents/websites from organisations, including: New Zealand College of Midwives, Nursing Council of New Zealand, Nursing and Midwifery Council, UK (formerly UKCC/ENB), Royal College of Midwives, College of Midwives of British Columbia, College of Midwives of Ontario, ACMI (earlier work), Nurses Board of Victoria, Nursing Council of Queensland, the World Health Organisation, Guilliland and Pairman (1995), Leap (2004).

relationship with the woman at the centre of practice as well as an explicit understanding of power sharing (Page, 1993; Pairman, 2000).

The rhetoric of 'The Cause': Informed Choice

The texts explore how the notion of 'informed choice' is essentially flawed, power being associated with the person who gives the information rather than the one who is struggling to make sense of decision making. The privileging of 'choice' belongs to a neo-liberal ideology that privileges the rights and responsibilities of the individual above the responsibility of the State to address inequalities. Any discussion with midwives needs to address the idea that the person who does the informing has the power in any given situation. Furthermore, the culture in which women are supposed to make choices often mitigates against any real sense of choice as identified on the Home Page of the MIDIRS Informed Choice web site:

> Medical hierarchies, power structures and the clinical environment make it difficult for some women to articulate their preferences. There has also been a divergence from acquiring client consent to a more complex notion of informed choice. (MIDIRS Home Page www.midrs.org Accessed 14 December 2004).

The rhetoric of 'The Cause': Evidence Based Practice

The problematic notion of 'evidence based practice' is explored fully in Chapter 4. There is no clear evidence to inform most clinical decision-making and midwives work in a culture that prioritises randomised controlled trials, one that often ignores qualitative data or women's needs to make spontaneous, instinctive decisions. The portfolio texts in this chapter addressed these issues and provided an opportunity to discuss how Lesley Page's (2000) concept of the *Five Steps to Evidence Based Practice* manages to embed the critiquing and applying of evidence within a woman centred framework for midwifery practice.

The rhetoric of 'The Cause': Midwives as Guardians of the Normal

The discussion studied here looked at the implications for women of terminology that describes birth as 'normal'; 'physiological'; spontaneous'; natural; or 'straightforward vaginal birth.' As in many discussions of this nature, midwives end up justifying the use of the word 'normal' as shorthand for the domain of the midwife, a sphere of practice that is identified as separate from technological or medical interventions. However, as Holly Powell Kennedy (2004b) identified in her paper at the Second Normal Labour and Birth Conference in Grange-Over-Sands, the notion of 'normal' mitigates against embracing the concept of each woman's birth being viewed by her as essentially 'special'.

In order to 'unpick' the implications of this for practising midwives, the discussions about 'midwives as guardians of the normal' in two of the portfolio texts draw on an important study of 1,464 births in five Consultant units in the United Kingdom (Downe, McCormick, & Beech, 2001). Once women who had artificial rupture of membranes; induction; acceleration; epidural anaesthesia; or episiotomy were removed from the equation, only 16.9% of women having first babies and 30.1% of women having a second or subsequent baby, could be classified as having a 'normal birth'. This study shrinks the domain of the midwife as 'guardian of the normal' and raises rhetorical questions about 'how we have failed in our guardianship' (Beech, 1997). Since the majority of midwives are working in institutions where 'normal' birth is not the most common experience for women, questions need to be asked about the tension between how we define our role and how it is played out in institutions.

The psychological effect of working in environments where midwives have to defer to doctors most of the time is hardly conducive to promoting a strong, confident midwifery workforce or to optimizing the benefits of the midwife-woman relationship (Kirkham, 2000; Kirkham & Stapleton, 2000). In this context, the rationale for promoting birth at home or in midwifery run birth centres as strategies to enable 'normal' birth and the empowerment of women begins to make sense. In rhetorical terms, this can be seen as building an argument, reaching a conclusion that is supported by reasons that also appeal to the emotions of midwives, who daily face a working environment where their power is diminished. As always, the purpose is to raise consciousness and promote action.

The rhetoric of 'The Cause': Articulating a vision

The notion of articulating a vision is described in all three texts as an important feature of coming together to affect change. This process is discussed by telling a legendry, 'thoroughly successful strategy' story. The tale of how a few midwives in the Association of Radical Midwives (ARM) came together for a weekend away and dreamt a vision (ARM, 1986) that then became a blueprint for midwifery development in the UK, as well as in Canada, New Zealand and indeed in Australia, is told over and again by many. The irony in this 'success story' is that the principles articulated in the Vision and outlined in the portfolio book chapter above, still need to be articulated; indeed, they form the basis of contemporary midwifery rhetoric and the arguments put forward in proposals penned by childbirth activists throughout the Western world:

Principles outlined in *The Vision*. Association of Radical Midwives, 1986.

- That the relationship between mother and midwife is fundamental to good midwifery care
- That the mother is the central person in the process of care

- Informed choice in childbirth for women
- Full utilisation of midwives' skills
- Continuity of care for all childbearing women
- Community based care
- Accountability of services to those receiving them
- Care should do no harm to mother and baby

The Rhetoric of 'The Cause': Influencing policy and organisational change

The development of the ARM Vision is a 'feel good' story that tells of how a small group of women representing so-called 'minority interests' made their voices heard in the corridors of power. This appeals to midwives who are painfully aware of the 'invisibility of midwifery' in Australia (Brodie, 2002) within the powerful hegemonies of nursing and medicine. The tale encourages a sense of what I call 'cluefullness' around the importance of 'seizing the moment' and understanding the ideology underpinning policy makers' decisions.

Organisational change in any discipline requires an examination of the social and political contexts within which policies are formulated (Gardner & Barraclough, 1992). This involves developing an understanding of the institutional structures, decision-making processes, and values held by policy makers. Most importantly, it involves an awareness of power relationships. Kathleen Fahy (1997) has explored how postmodern notions of power and subjectivity can be used to uncover the strategies and tactics of power, submission, resistance and change and the way in which organisational structures and social processes reinforce medical dominance. She makes a case for 'an embodied rationality' that allows for feelings, emotions and 'a sense of active excitement' to co-exist with rationality in the interests of strengthening the theoretical power of emancipatory studies (Fahy, 1997 p.32). In the situations addressed in the portfolio texts, I was aware of attempting to engender this sense of 'active excitement' as a strategy to encourage midwives to be actively involved in challenging and changing the structures that inhibit the potential of midwives and midwifery.

The discussion about midwifery knowledge that finishes the seminar in New Zealand introduces concepts that are explored more fully in the next Chapter.

Chapter 3

'A Midwife is a Midwife is a Midwife...'

> At its core, midwifery is a celebration of diversity and new possibilities. It not only restores ancient elements of community and female familiarity, but argues for an honouring of these elements (Burtch, 1994 p.53).

Chapter 3 builds on the rhetorical innovations identified previously by exploring definitions and descriptions of midwifery as a way of articulating and positioning midwifery as a valuable profession in its own right. The rationale for each text will be explored and links will be made to identity and the strategies used to convince others of the potential value of midwifery. A critique of how midwifery icons from the past are portrayed in the struggle for collective identity, will accompany an article defining midwifery, in a 'coffee table' dictionary of medicine. This analysis of midwifery history provides a starting point for a discussion of how Australian midwifery is articulating a separate identity to nursing. Arguments regarding how that process can be effective are articulated in a conference paper given at an Australian College of Midwives' conference. Descriptions of the unique nature of the midwife-woman relationship are explored further in a book chapter that explicates how midwifery philosophy underpins practice. In contrast, two formal submissions are included that address the barriers in regulation and funding systems that impede the development of midwifery's potential role in Australian maternity systems. Finally, a conceptual map of community midwifery employs visual symbols in order to express the concept of 'midwifery as a public health strategy' through graphic means of persuasion.

Portfolio Text 4:

'Midwifery' - Entry in the *Oxford Illustrated Companion to Medicine.* Eds: Stephen Lock, John M. Last, George Dunea. (2000). Oxford University Press. pp. 493-498.

Portfolio Text 5:

PowerPoint slides for a conference paper: *Defining midwifery as we develop woman-centred practice.* Presented at the Australian College of Midwives 11th Biennial Conference in Hobart, Tasmania, September 1999.

Portfolio Text 6:

A book chapter: The less we do the more we give. Chapter 1. In: Mavis Kirkham. (Ed). *The Midwife-Mother Relationship*. 2000. London. Macmillan Press.

Portfolio Text 7a:

Submission to the Nurses Board of South Australia: *Strategies to protect the public and ensure the highest standards in midwifery education and practice* on behalf of the South Australian Branch of the Australian College of Midwives

Portfolio Text 7b:

Submission to the Senate Inquiry into Public Hospital Funding on behalf of the South Australian Branch of the Australian College of Midwives

Portfolio Text 8:

Community Midwifery: a conceptual map: OHP slide and explanatory notes

Portfolio Text 4

Leap N. (2000: 493-498)

'Midwifery' - Entry in the Oxford Illustrated Companion to Medicine.

Eds: Stephen Lock, John M. Last, George Dunea. Oxford University Press.

Portfolio Text 5

PowerPoint slides for a conference paper: *Defining midwifery as we develop woman-centred practice.* Presented at the Australian College of Midwives 3rd Biennial Conference in Hobart, Tasmania, September 1999.

Portfolio Text 6

The less we do the more we give. Chapter 1 in: Mavis Kirkham. (Ed). *The Midwife-Mother Relationship.* (2000). London. Macmillan Press.

Portfolio Text 7a

Leap N & Cornwall C (1999). *Strategies to protect the public and ensure the highest standards in midwifery education and practice*. Submission to the Nurses Board of South Australia by the South Australian Branch of the Australian College of Midwives.

This text is reproduced and analysed here with the kind permission of Chris Cornwell and the Australian College of Midwives – South Australian Branch (Appendix A).

Portfolio Text 7b

Leap N & Cornwell, C (1999). Submission to Senate Inquiry into Public Hospital Funding on behalf of the South Australian Branch of the Australian College of Midwives.

This text is reproduced and analysed here with the kind permission of Chris Cornwell and the Australian College of Midwives – South Australian Branch (Appendix X)

Portfolio Text 8

Leap, N. (2002). *Community Midwifery: a conceptual map:* OHP slide and explanatory notes.

Community Midwifery: a conceptual map

Introduction and Background

The idea of designing a conceptual map of 'community midwifery' came to me while encouraging a student to design a conceptual map to explain their (unrelated) research project. I heard myself extolling the usefulness of graphic designs for explaining inter-related concepts at a glance and tucked away in my mind the possibility of engaging in a similar activity to explain the thrust of my work as Director of Midwifery Practice for South East Sydney Area Health Service, namely, developing community based midwifery continuity of care.

For some time I had been struggling to explain to a range of practitioners and policy makers how, where care follows the woman across the interface of community and hospital services, midwives might operate mainly in the community. My explanations of 'midwifery as a public health strategy' (Kaufmann, 2000, 2002) were met with, at best, quizzical interest and at worse, hostility, in particular from child and family health nurses (CFHNs) and GPs who see the postnatal period as their domain. As part of the *Families First* initiative[1] I was keen to develop a more integrated service between midwives and practitioners based in the community. I was finding that, both midwives and CFHNs, were struggling to understand how their services might dovetail in the early postnatal period. This was exacerbated by changes enforced by *Families First.* Child and family health nurses were used to running clinics – and sometimes groups – in health centres, but they were now required to engage in 'universal home visiting'. My aim was to suggest that some of this home visiting could be carried out by community midwives, who would liaise closely with the CFHNs and ensure that women accessed their services.

In the Australian context, there is no statutory provision of postnatal home visiting services and it is rare for the majority of midwives to be able to see how their role might extend beyond the confines of fragmented care in hospital wards. This is reinforced by midwifery education. As identified in the Australian Midwifery Action Project (AMAP, 2003), most midwifery students get little, if any, exposure to working in the community. Postnatal home visiting occurs in some hospitals for women who go home before 48 hours after birth, but usually this service is provided by midwives the women have not met before. Midwifery visits tend to end before the first week following birth is completed and rarely is the midwife working in a primary health care or community development role.

[1] Families First is a coordinated strategy sponsored by the NSW Government to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well-adjusted children. The aims of Families First is to work through a coordinated network of services, to support parents and carers raising children aged 0-8 years to help them to solve problems early before those problems become entrenched.

The conceptual map (plus explanatory notes) identifies how the majority of midwifery activity can take place in the community. It aims to show at a glance the important role the midwife has in collaborating with other agencies and community based networks. Importantly, it shows the discreet period of time in which the midwife provides continuity of care and suggests possibilities for collaboration where midwives are based in child and family health centres. In workshops and planning meetings, I have found the conceptual map to be a useful tool in explaining the rhetorical innovation of 'community midwifery' and the potential value of midwives within public health strategies.

Community Midwifery – notes to explain the slide

The slide is a visual representation of collaborative midwifery care in the public health service that follows the woman across the interface between community and acute settings. Most of the care is provided in the upper half of the diagram (community) and the midwife only has to provide care in the hospital setting where referral or consultation is required or if the woman gives birth in hospital

This is an evidence based model that has been shown to improve outcomes for women and their families while enabling midwives to work according to the full potential of their role.

Midwifery has been identified as a public health strategy in other western countries. Midwives are ideally placed to identify women's needs in early pregnancy and access services and support structures for women in both acute and community settings.

Midwives working in this way address the strategies outlined in *Families First* and collaborate closely with other practitioners, particularly obstetricians and child and family health nurses.

The slide represents a flexible model, the components of which might vary considerably but could include the following:

- Midwifery practices are based in the community and are therefore collaborative and accessible – e.g. in a Child and Family Health Centre, Community Centre, Child Care Centre, Women's Health Centre.
- For women who do not readily access services via GPs in early pregnancy, a proven strategy is to offer free pregnancy testing and counselling in the midwifery practice.
- The midwives can provide the booking visit in the woman's home

- At the booking visit the woman's primary midwife provides psychosocial screening including screening for domestic violence. Women are also offered the range of screening tests and investigations and options for their care and place of birth.
- The woman's primary midwife takes responsibility throughout the pregnancy and through to the early weeks following birth for ensuring that all referrals and investigations are carried out according to clear guidelines for referral and consultation.
- This includes making sure that the woman knows about support groups in her area and may include referrals to agencies such as Housing and DOCS (Social Services).
- The midwives in the practice facilitate free antenatal groups that women can attend at any stage of their pregnancy. The idea is that women learn from each other and build support networks in their local area.
- If the woman needs to see a doctor, the midwife collaborates closely with that practitioner. In some cases this might mean attending the consultation with the woman in order to facilitate collaborative planning.
- At 36 weeks, there is the potential for the midwife/midwives to meet in the woman's home with the woman and the people who will be supporting her in labour and the early postnatal period. Planning can occur for labour and the postnatal period.
- Final decisions about the place of birth can occur in labour when it is clear whether all is straightforward. Midwives can visit the woman at home in early labour to avoid unnecessary hospitalisation.
- Following the birth, if all is well, the woman can go home within a few hours if she wishes.
- The midwife/midwives will continue to provide care in hospital and in the community as appropriate up until 4 – 6 weeks following birth.
- During this time, midwifery services will dovetail with services offered by child and family health nurses and GPs.
- Midwives will ensure that women access postnatal support groups and services in the community.

Discussion:

'A Midwife is a Midwife is a Midwife…'

> I am interested in the idea of deriving a set of *midwifery* based values and assumptions. These have rarely been explicitly articulated, partly because the subject matter of midwifery is easily conflated with that of nursing and obstetrics. It is a truism of radical midwifery that these disciplines are distinct. All three have different histories and different fields of expertise. Blurring the distinctions between them could be seen to have benefited both nursing and medicine to the detriment of midwifery (Taylor, 2001 p.6).

In different ways, each of the portfolio texts in this chapter addresses argumentation regarding definitions and descriptions of midwifery that serve to explain how the role and scope of practice of midwives can best meet the needs and interests of childbearing women. This linking of descriptions of midwifery to improved outcomes for women and their families has been the major professionalising strategy used by midwives over the centuries in Western countries, including Australia (Adcock et al, 1984; Burtch, 1994; Donnison, 1977; Kennedy, 2000; Kennedy, Rousseau, & Kane Low, 2003; Lay, 2000; Leap & Hunter, 1993; J Sandall, Bourgeault, & Meijer, 2001b; Summers, 1998; Witz, 1992). The portfolio texts in this chapter were chosen in order to explore the rhetorical innovations that promote midwifery and claim a set of universal midwifery core values and behaviours. The contemporary midwifery rhetoric of 'woman-centred care' is articulated as different from the care given by other practitioners in that, throughout centuries and across cultures, women can be seen to ask midwives to be alongside them in their journey to motherhood in a relationship of mutual trust and respect embodying feminist principles (Guilliland & Pairman, 1995; Kitzinger, 2000; Thompson, 2004). The roles women ask of midwives are those of support and skill in addressing the physical, emotional, social and spiritual aspects of a rite of passage that has far reaching consequences for all involved and for the well being of societies (Kirkham, 2000; Kitzinger, 1988; Thompson, 2004).

Any persuasive intent to raise the profile of midwifery is also mindful of the social and cultural influences that hamper the acceptance of midwifery's potential role in society and health care reforms. As identified by Raymond De Vries, confirmations of the value of midwifery need to be explored alongside 'new understandings of the forces that prevent the wisdom of midwifery from being realized' (De Vries, 1996 p.181). An analysis of the portfolio texts in this chapter allows me to situate my work against the backcloth of midwifery development in Australia over the last five years and describe the role that rhetorical innovation has played in addressing the challenges and achievements involved in promoting midwifery.

Addressing the midwifery quest for universality

In analysing the portfolio texts for their rhetorical innovations, contemporary tensions in the foundations of midwifery discourse are revealed. As is evident in the texts, descriptions of midwifery embrace post-structural concepts such as diversity, multiplicity, uncertainty and what Kim Walker (1995 p.12) describes as 'projects of possibility'. The language of 'possibility', initially suggested by Michel Foucault, is irresistible to midwifery and rhetorical scholars:

> … it [the language of possibility] evokes the care that one takes for what exists and could exist; a readiness to find strange and singular what surrounds us; a certain relentlessness to break our familiarities and to regard otherwise the same things; a fervour to grasp what is happening and what passes; a casualness in regard to the traditional hierarchies of the important and the essential.
> (Foucault cited in Lotringer, 1989 p.198)

The 'readiness to find strange and singular' is central to woman centred midwifery practice that centres on individual women's experiences and situations. The processes of defining and describing midwifery are therefore, to some extent, self-defeating, given the complexity and individuality of each woman's experience of childbirth within her social environment and the myriad range of midwifery skills involved in being 'with woman' [mid wyf]. Reducing events to accentuate their essential traits or final meanings can mask what Foucault called 'the profusion of tangled events… the marvellous motley, profound and totally meaningful' arising from the disorder of our complex worlds (Foucault, 1977 p.155). However, the texts in this chapter reflect how feminist midwifery discourse treasures an identity that encompasses the universality of midwifery in terms of how the 'mid-wyf' [being with woman] role is played out across cultures and throughout centuries. There is an acknowledgement of how discursive practices within a culture provide a framework for understanding but, conversely, there is a yearning for commonalities that permeate through the boundaries of culture and that bind us together as midwives committed to 'The Cause'. The challenge in writing texts that make the case for midwifery is to allow for a sense of multiple descriptions, subtle innuendo and limitless possibilities, while exploring the parameters of practice that describe the value of the unique role midwifery plays in the lives of childbearing women. An appreciation of how midwifery negotiates this process inevitably begins with feminist critiques of how it has occurred over the centuries.

Midwifery rhetoric: echoes from the past

> The history of midwifery foreshadows many of the issues that drive modern conversations about midwifery. Or, to reverse this point of view, modern public debates about midwifery

> resonate with echoes from the history of midwifery, particularly in its relationship with medicine and the state (Lay, 2000 p.43).

The first portfolio text was commissioned by Professor Stephen Lock, lead editor of the revised version of the *Oxford Illustrated Companion to Medicine* (*OICM*). My brief from him was to write an overview of midwifery that would draw on historical as well as contemporary issues concerning midwifery, with a view to informing and entertaining the readership of this 'coffee table' anthology. Mild controversy was encouraged in the interest of attracting the attention of the reader. The text therefore does not shy away from making the case for government funded home birth and community based, midwifery caseload practice; neither does it ignore the interdisciplinary tensions between midwifery, medicine and nursing. In writing this text, I could only imagine who the audience might be and therefore saw this as an opportunity, as well as a challenge, to render midwifery visible alongside medicine in a text that would encompass past, present and future descriptions of the important role midwives play in society.

The midwifery overview begins as any text with such an overarching task ((Donnison, 1977; Kitzinger, 1988) with the somewhat grandiose claim that midwifery is the oldest profession in the world. The wording is carefully chosen in terms of women across the world choosing other women to attend them (Kitzinger, 1988; Wilson, 1995). This is a rhetorical strategy that links a time honoured custom to the contemporary claim seen in other portfolio texts here, that, unlike a patient requiring nursing care through what might be termed an 'episode of care', women can choose their midwife to be alongside them on their journey through labour and the early weeks of new motherhood. A statement from the World Health Organisation is drawn on to reinforce this rhetorical positioning of midwives as 'the most appropriate and cost effective type of health care provider to be assigned the care of normal pregnancy and normal birth…' (World Health Organisation, 1996 p.6).

The next rhetorical strategy employed is the linking of this time-honoured role with nomenclature. The rhetoric of feminist midwifery enjoys the fact that the word 'midwife' originates from the Anglo-Saxon 'mid wyf' meaning 'with woman' and that in many other languages, 'midwife' has similar meanings such as 'wise woman' in the French 'sage femme' (Kitzinger, 1988). Common nomenclature across centuries and cultures allows for a universalising process that strengthens the rhetoric of midwifery through the emotional bonds of of identity embedded in language. In her extensive exploration of birth in different cultures and throughout centuries, Sheila Kitzinger (2000) identifies the contrast between the social and technocratic models of childbirth. Traditionally, the role of the midwife is based in the social model and Kitzinger makes a strong case for the universality of this role:

> In all cultures, the midwife's place is on the threshold of life, where intense human emotions – fear, hope, longing, triumph and incredible physical power – enable a new human being to emerge. Her vocation is unique (Kitzinger, 2000 p.164).

The midwifery continuum across centuries is identified in the *OICM* text through a portrayal of some of the famous midwives who have earned a place in Western historical accounts of midwifery's gendered struggles in the face of the medicalisation of childbirth. It can be argued that links with the past play an important role in every individual's experience around childbirth. For midwives, these links may also contribute to feminist analyses of midwifery. A 'Cause' thrives where it has icons from the past to bolster ideology and inspire a sense of continuity. The *OICM* text therefore attempts a 'snapshot' of the rhetoric employed by iconic midwives. There is an inference that their voices resonate through the centuries and add to a conceptualisation of how patriarchal forces conspire to constrict midwifery's potential contribution (Lay, 2000; Murphy-Lawless, 1998). It is not unusual to find colourful quotations such as those offered here from 17th and 18th century midwives Jane Sharp, Elizabeth Cellier and Elisabeth Nihell, in texts that focus on socio-cultural critiques of midwifery and obstetrics (Donnison, 1977; Lay, 2000; Murphy-Lawless, 1998). As Jo Murphy Lawless (1998) identifies, although specific techniques in birth management may have changed, the focus of arguments between midwives and doctors and the problem of agency, identified in midwifery tracts over the past 300 years, remains unresolved.

The rhetoric of the witch

Any historical overview of midwifery has to address the persecution and public killing of midwives in Europe in the fourteenth and fifteenth century. The *OICM* text is cautious in not dwelling on the misogyny and horror of these events. A justification of this positioning is in order given that the 'witch burnings' have become iconic in radical feminist accounts of midwifery and women's heath (Purkiss, 1996).

Twentieth century feminists bemoaned the lack of 'herstory', the paucity of documents recording the lives of everyday women over the centuries. We studied records related to midwives and childbirth in attempts to elicit clues that might address this invisibility (Leap & Hunter, 1993). The popular work by Barbara Ehrenreich and Deirdre English, (1973) *Witches, Midwives and Nurses: a history of women healers* was a prime example of such attempts. Here was a clear articulation of how 'our oppression as women health workers is inextricably linked to our oppression as women' (p.41). This study of the control of women's bodies by the Church, the State and male doctors and the persecution of midwives and 'women healers' as 'witches' inspired many of us engaged with the politics of childbirth in the 1970s and '80s. I note that it is still a referenced text in many midwifery

curriculum documents and today, urge caution in how such texts are discussed with students. Quite apart from the questionable notion of reinforcing images of women as powerless martyrs, a more complex analysis of how 'herstory' is portrayed is in order.

In *The Witch in History and Society,* Dianne Purkiss (Purkiss, 1996) explores how various groups have used the image of the all powerful, persecuted 'witch' as political rhetoric and identifies the inaccuracy of claims that millions of women healers and midwives were burned. Historians like Purkiss do not seek to deny or trivialise the fact that probably thousands (not millions) of women in Europe were tortured and killed by the Inquisition and that midwives were amongst these. They point out though, that not all those who were murdered were midwives; some were men and records show that, in some cases, midwives were responsible for bringing the accused to the attention of the persecutors and were involved in giving evidence at trials. In exploring why feminists like Ehrenreich and English would 'invent a holocaust', Purkiss suggests that the story of the persecuted, midwife-healer, tortured and condemned to death by the male supremacy of the Church as a 'witch', provides the perfect vehicle for a polarisation of 'good and evil', oppressor/oppressed, 'persecuting men and persecuted women'. Everybody knows exactly where they stand. The ideology of feminism is enhanced by the notion of a continuum of the oppression of women and identification with our 'sisters' from the past who were martyrs at the most extreme end of male domination.

The use of the midwife/witch as an icon suffering the full force of patriarchal oppression is also explored by Rosalind Coward (1989) in her biting critique of the 'alternative health' movement. Coward suggests that this view of witchcraft has laid the foundations for contemporary 'feminist' witchcraft as well as interpretations of the midwife as wise woman, earth mother and healer. The witch is used as the repository of ancient, pre-patriarchal feminine values, namely all that is humane, egalitarian and ecological. The medicalisation of childbirth and the displacement of midwives stems from the persecution of witches:

> The whole history of midwifery and the issues raised by non-medicalised (or natural) childbirth have been taken up as a vital struggle between the natural, powerful and creative forces of women opposed to the destructive, negative powers of men and professionalism. (Coward, 1989 p.165).

Coward suggest that this polarisation has played a crucial role in the discourse of the alternative health movement, including the 'natural childbirth' movement and the neo-liberal concept of individual responsibility for health. She argues that personal responsibility for the self rarely generates political action to transform social structures: 'Action simply becomes a matter of

personal choice between two routes, rather than a matter of creating a different society with different values' (Coward, 1989 p.205)

Caution about using the witch as an icon should not lead to an underestimation of the role misogyny and gender have played throughout the centuries in relation to midwifery. The *OICM* text attempts to combine 'evidence that midwives were among the thousands who were persecuted and executed in the witch hunts' with an overview of the denial of access to education for women and the increasing male domination of childbirth through the exclusive practices and discourses of science and medicine.

Being 'with woman' across centuries and cultures

There is an underlying suggestion throughout the text that contemporary midwifery discourses are shaped and reinforced by historical forces related to power and control, a phenomena explored by Arney in his seminal [ovular] text, *Power and the Profession of Obstetrics* (Arney, 1982). There is a non-apologetic gesture to provide an historical overview that encompasses what Larkin (1983) has referred to as 'occupational imperialism' - medical dominance that employs tactics of demarcation and exclusion in order to subordinate or eliminate less powerful groups, in this case, midwives. However, in the *OICM* text, there is no glossing over similar professionalising strategies spearheaded by socially influential, aristocratic and middle class midwives that led to the demise of the unofficial midwives chosen by women throughout the centuries (Benoit, 1994; Heagarty, 1996; Leap & Hunter, 1993; Sandall et al., 2001b; Witz, 1992). The tensions between midwifery and nursing are also addressed in the context of the increasing medicalisation and hospitalisation of birth.

The essentialist rhetorical notion of women asking midwives to be alongside them on their journey through childbirth and the significance of this relationship for all concerned, including societies through the ages, finishes and ends the *OICM* text and underpins the arguments in the next portfolio text, a conference paper entitled, *Defining midwifery as we develop woman-centred practice.*[2] This paper was given at the 11th Biennial Conference of the Australian College of Midwives and rhetorical analysis of its presentation allows for reflection on the changes in Australian midwifery that were taking place at that time.

The midwifery revolution

The conference paper begins with an appeal for solidarity and common purpose through situating myself as a new Australian resident alongside a rousing attempt to engender enthusiasm. A sense of extraordinary achievement and change is implied by the use of the word 'revolution'[3], which is linked to the midwifery rhetoric of enabling woman centred care:

> I want to acknowledge that, although at times it may not seem like it, a midwifery revolution is taking place across Australia. Changes are happening that place women at the centre of care, changes that could not have been predicted two years ago when I attended my first ACMI national conference as a newly arrived Australian resident.

[2] The conference paper is reproduced in this chapter in the form of the PowerPoint slides that accompanied it. This enables a clear outline of the rhetorical concepts employed in the presentation of the paper. Where deemed useful, quotations from the paper as it appeared in the Conference Proceedings are included.
[3] Definition of 'revolution': forcible overthrow of government or social order; any fundamental change or reversal of conditions (Oxford Dictionary of Current English)

> For example, in South Australia alone, every metropolitan hospital and several rural hospitals are working towards midwifery-led models of care, such as caseload practice. Furthermore, the two universities that provide midwifery education in Adelaide have joined forces and will coordinate a national initiative to develop three-year Bachelor of Midwifery programmes, commonly known as 'direct entry'. (Portfolio text 5)

The examples given are worthy of further discussion and in Chapter Four, the story of the development of the 'revolutionary' three-year Australian Bachelor of Midwifery is told. In order to understand the confidence of the rhetoric regarding midwifery-led models of care, it is useful to back track a year to a conference that is still seen by many as a turning point in Australian midwifery development. The 'New Models of Maternity Service Provision: Australian Midwifery Perspectives' conference was held in 1998 in Adelaide. Hosted by the Women's and Children's Hospital and Flinders University, the conference brought together midwives from across Australia to showcase the innovative projects that were offering women midwifery continuity of care. Several of these had been established for a few years as a result of the Commonwealth Alternative Birthing Services funding but the majority of projects were in their infancy. The atmosphere at this conference was one of highly charged expectation. It seemed as though Australian midwifery was on the brink of fundamental changes and that the recommendations of government documents, such as *Options for Effective Care in Pregnancy and Childbirth* (NHMRC, 1996) would be implemented.

The 'New Models' conference is remembered by many with great affection and pride as it was the first large conference that did not rely on speakers from overseas to attract delegates. This was a morale boosting exercise that was successful in promoting a sense of common purpose and identity. In writing this text, six years later, I returned to the transcript of a speech that I gave, as Conference Convener, to round up the conference and unsurprisingly found that the final sentence made the rhetorical claim that '… the revolution has begun for Australian maternity services'. The speech is reproduced here since it is saturated with midwifery rhetoric that appeals for 'revolutionary' action:

> The aim of this conference was to bring together maternity service providers who are at the cutting edge of change in Australia. We purposely did not invite any overseas speakers, as we wanted to celebrate what is already happening here in Australia and focus on how we might pull together for the future, learning from each other's experience.
>
> There were eighteen invited speakers who presented at the conference as well as sixteen concurrent sessions. The speakers and 250 delegates came from all over Australia and represented rural and remote, as well as metropolitan areas.
>
> The conference was opened by Senator Meg Lees, leader of the Australian Democrats, who gave a rousing speech, demonstrating that she had a fine understanding of midwifery politics. Pat Brodie, the Keynote Speaker, set the tone for the two days by describing some of the challenges for midwives in aligning themselves with women, implementing continuity of care and simultaneously changing the system. There is not time to do justice

to all of our speakers but please remember that the conference proceedings are available on disc as well as in hard copy. Instead, I will give you a taste of how I have resolved the daunting task of summing up this wonderful conference.

I find myself reflecting that throughout the presentation, 'buzz' words and themes emerged that all seemed to begin with **'C'** or **'P'**![4] This seems a far cry from the days when we used to refer to the meagre 'three Cs – **Choice, Control and Continuity** – when describing the need to design and implement new maternity services.
Coming together in **Partnership** with women requires **Creativity** and **Commitment** to redefining what we mean by **Professionalism.**
Community based projects that work within a **Philosophy** that addresses **Primary Health Care Principles** were advocated at the conference in order to address **Power** issues and explore the Potential and Possibilities of providing **Care that is woman-Centred.**
The wide-ranging experiences presented described the importance of understanding the **Politics** and **Challenges** associated with **Change**. **Continuity of Care** by midwives is **Controversial** and midwives need to be **Political**, have **Purpose**, **Positivity** and **Passion** in **Pursuing 'the Cause'**!
We should also be putting our energy into transforming and strengthening our **College** by encouraging midwives to join and **Participate**.
The key to safe services for women is seen to lie in good **Communication**, **Collaboration**, **Cooperation** and **Consultation with other Practitioners**.
As well as ensuring that regulation and education address the issue of safe **Practice** and **Competency**, there needs to be recognition that midwives working 'with women' undergo huge shifts in **Personal** development as they become **Confident Practitioners**.
We need to develop skills in **Proposal Writing** and show that **Caseload Practice** is **Cost-effective**.
When organising **Conferences**, we should avoid **Computer Catastrophes** now that so many people are moving towards **PowerPoint**. In this instance, we should take heart that, in spite of these technical hitches, we can move forward in **Partnership with Consumers**, full of **Confidence** that the revolution has begun for Australian maternity services.

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Pragmatic changes

A year later, in the portfolio text conference paper, I made the claim that the development of midwifery-led models and 'direct entry' midwifery education programs was forcing a pragmatic, rather than an ideological need to articulate midwifery as a separate profession from nursing. This is a rhetorical strategy to move the argument away from the vulnerabilities of ideological positioning to specific operational issues where they are less open to challenge. Pragmatic arguments identify recommendations or courses of action based on consequences (Herrick, 2004). In this case, the fallacy of this tactic is that the very notion of pragmatism over-ruling ideology is open to challenge, particularly since complex values and emotions concerning personal and professional identity are at stake. However, using the collective pronoun to support a sense of solidarity, an attempt is made to support the assertion of pragmatism with reasoning based in examples, the consequences of which would render midwifery visible and therefore stronger and more able to develop its potential.

[4] The words in bold were presented on overheads as I spoke each one.

The naming of midwifery

> We find ourselves able to justify changing the names of our Schools of Nursing to include Midwifery in the titles in order to market the new 'direct entry' programmes. (Portfolio text 5)

The argument that midwifery could not be marketed where it was hidden in the websites of Australian university nursing departments had indeed driven changes in nomenclature to include midwifery. The emotional sense of identity as well as the pragmatic repercussions associated with these changes should not be underestimated. This was articulated by Professor Jill White [5] in an oration given at the same conference as the one where I gave the paper being analysed here:

> Naming is a substantial political issue. It represents our identity, our sense and understandings of ourselves… It has been a potent and powerful event within the university and within NSW health care. …The political power of naming can and must never be underestimated. (White, 1999 p.7-8).

White identified that this name-change, as well as the introduction of two new doctoral programs - a Professional Doctorate in Nursing and a Professional Doctorate in Midwifery – had challenged members of the faculty and university to examine their understanding, as well as their lack of understanding, of how nursing and midwifery constitute separate disciplines. According to White, the most important challenge though, was for midwives ourselves to be sure that we are in accord about what it is about our practice that defines it and us; what it is that differentiates our practice from that of nursing or indeed, obstetrics:

> It is therefore professionally imperative and socially and professionally responsible to be sure we are speaking the same language, not just using the same words (White, 1999 p.8).

The importance of Jill White's challenge resonates five years later where Australian (and UK) midwives are engaging in national debates about the role and scope of practice of the midwife. Strong arguments are being put forward for midwifery extending, or not extending, beyond four to six weeks in the postnatal period. This mirrors fraught international debates about whether midwifery should continue address a discrete 'event' that finishes around six weeks following birth or whether it should be re-defined within a framework of 'reproductive health worker', to include a broader role of women's health, sexual health and child and family health. The outcomes of these debates will have implications for the re-writing of the international *Definition of a Midwife*[6] (WHO, 1992) as well as how midwifery negotiates its separate identity from nursing.

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[5] Jill White, Dean of the first Faculty of Nursing to change its nomenclature - to Faculty of Nursing, Midwifery and Health in early 1999.

[6] Jointly developed by the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics. Adopted by the International Confederation of Midwives Council 1972. Adopted by the International Federation of Gynaecology and Obstetrics 1973. Later adopted by the World Health Organization. Amended by the

> **Negotiations for annualised Salaries**
> In union negotiations for the annualised salaries that will enable the occupational autonomy and flexibility associated with midwifery caseload practice, we find ourselves asking the Australian Nursing Federation to re-consider its nomenclature and policies. In particular, we're asking the ANF to reconsider its policy that midwifery is a branch of nursing as well as its policy of opposing direct entry midwifery education. (Portfolio text 5)

Negotiations with the nursing union, the Australian Nurses Federation (ANF) were less effective than is implied here. In South Australia it would be a further four years before the union and state government finally signed off on an annualised salary award that would enable midwifery caseload practice to start at the Women's and Children's Hospital, Adelaide. Although 'talked up' in this conference paper, relationships were extremely fraught in the light of midwifery's efforts to define itself as a separate discipline around the issue of the introduction of a three-year Australian Bachelor of Midwifery. As can be seen in the portfolio text, I was anticipating the opposing points of view identified here in an editorial the following year in the union's journal by Jill Iliffe, President of the ANF:

> The ANF does not support the separation of midwifery into a separate profession. Nursing is a holistic profession, providing services to people of all ages, from conception to death. Birthing is a very special life event, but it is just one of many life events for women and families. It is not separate from, but part of the whole. To have a separate profession for birthing is as illogical as a separate profession to care for people who are dying, or a separate profession to care for people with mental health problems. Birthing should not be seen in isolation from the broader picture of women's health, sexual health, child and family health, or mental health, to name just a few (Iliffe, 2000 p.1).

In making a plea for rhetorical positioning that respects the sort of arguments posed here by Iliffe, I was employing what Herrick (2004) describes as one of the virtues of argumentation ethics: the need to affirm a value for people as both givers and hearers of reasons, even when we do not consider their position reasonable. For many Australian nurses, some of whom also practise as midwives or hold a midwifery qualification that they do not utilise, the concept of midwifery being a separate profession to nursing threatens deeply held beliefs and identities. As highlighted by the Australian Midwifery Action Project research (Brodie & Barclay, 2001) one of the difficulties in identifying how many practising midwives there are in Australia lies in the fact that many nurses continue to register as midwives when they are no longer practising midwifery. There is a pride in being a 'dual certificate' nurse that needs to be understood and respected. Each of the portfolio texts analysed in this chapter attempts to engage midwives who also identify as nurses and challenge their thinking without alienating them through direct confrontation. This is a key strategy of rhetorical innovation.

International Confederation of Midwives Council, Kobe October 1990. Amendment ratified by the International Federation of Gynaecology and Obstetrics 1991 and the World Health Organization 1992.

Articulating midwifery as a separate profession to nursing

The portfolio conference paper reinforces its articulation of midwifery as a separate profession by telling a personal story.

> At a personal level, I have engaged in numerous discussions to justify my position as a non-nurse. I have had to respond to genuine concern that 'direct entry' midwives cannot respond safely in obstetric emergencies or work with women with medical problems because they are not nurses. I have had to register as a nurse in order to register as a midwife in Australian States. I have joined a nursing union because there is no midwifery equivalent in this country. This has sharpened my understanding of the arguments in a way that was never necessary when I lived in a country that acknowledges midwifery as a separate profession to nursing in statute. (Portfolio text 5)

The important sentence embedded here is the one about justifying my ability as a 'direct entrant' to respond safely to emergencies and when working with women who have medical problems. The purpose of this statement is to reassure the audience that midwives who are not nurses are safe practitioners while appearing to assume that they know this already. I am also acknowledging here that developing arguments about this subject is challenging and complex. To some extent, what follows is meant to be a resource for midwives in terms of avoiding 'old fashioned rhetoric' that alienates and can be discounted as fallacious, followed by a sharing of potentially successful rhetorical arguments describing the unique characteristics of midwifery. The basis of the reasoning is that midwives need to find respectful ways to argue why midwifery is different to nursing and why this matters. The paper walks through commonly used arguments identifying their fallacious and sometimes inflammatory content:

> In moving forward, I suggest that as midwives, we need to be able to engage our nursing colleagues in a mutually respectful debate that avoids old-fashioned rhetoric and alienation. Old fashioned rhetoric about midwifery being different from nursing and medicine because it adopts a 'wellness,' holistic approach is no longer useful in a culture where primary health care philosophy and politics have permeated the education and working environment of all health care workers, including nurses. It is particularly offensive to our nursing colleagues to trot out the following statements:
>
> - *Midwives work with healthy well women and nurses work in a sickness model*
>
> Leaving aside the fact that many nurses do not work within a 'sickness' model, what does this say about how midwives work with women who are unhealthy and not well?
>
> - *Midwives work holistically*
>
> A nursing philosophy of care includes an holistic approach and to suggest that this is particular to midwifery is an insult to other practitioners.
>
> - *Nurses are doctors' handmaidens whereas midwives are practitioners in their own right*
>
> Midwives need to recognise that many nurses are also practitioners in their own right. It also needs to be acknowledged that many midwives are working in systems that make it impossible for them to work as 'practitioners in their own right' and that there are also many who actively do not want to work in this way. (Portfolio text 5)

In an article published by Jill Iliffe (2001) some years later, many of her arguments reflect those anticipated in the ACMI conference paper. All of these depend on the premise that midwifery is a specialty of nursing:

- Obstetricians, gynaecologists etc do not consider themselves as a separate profession from medicine
- Midwifery is a regulated post-registration nursing specialty
- Nursing encompasses a continuum of care across the lifespan with a focus on wellness
- Nursing includes health promotion, health education, health maintenance
- Assisting women to birth is part of the holistic care of women and their families

The claim that nursing is provided from a medical model of care which does not support holistic practice, may have been justified ten years ago, but is not relevant today

- Nursing education is provided within a primary health care framework. With a strong emphasis on a continuum of care from and to the community where people live and work
- Care once provided by nurses is already being given to others. To fragment nursing care and the profession further has the potential to destroy the profession without enhancing care to birthing women.
- Midwifery has been at the forefront of much pioneering and innovative practice in Australia. The nursing profession has benefited greatly as a result. Midwifery has also benefited from nursing initiatives, such as the Nurse Practitioner project.
- A broadly based education program enhances career opportunities. Nursing allows for moving within and across specialty areas.
- Nursing is under so much threat from external sources, the profession cannot afford to be divided against itself

Iliffe (2001) completes her explanation of why midwifery is a specialisation of nursing by adopting the commonly used strategy of working together towards common goals, 'whilst acknowledging our unique differences'.

The bottom line...

Once the portfolio conference paper has addressed how midwives might engage in effective discussions with nurses regarding our separate roles, it poses the notion that the 'bottom line' for defining midwifery has to be improving outcomes for women and their families. The rest of the conference paper offers descriptions of the unique role of midwives in being alongside women and enabling situations that enable women to become confident mothers. These description are

explored more fully in the next portfolio text, a chapter in a book edited by Mavis Kirkham (2000): *The Midwife-mother relationship.*

The less we do, the more we give: the ethical journey

The philosophy and particular nature of midwifery care is explored in the book chapter with practical references to an approach that:

- Minimises disturbance, direction, authority and intervention
- Maximises the potential for physiology, common sense and instinctive behaviour to prevail
- Places trust in the expertise of the childbearing woman
- Shifts power towards the woman. (Leap, 2000 p.2)

An exploration of the 'with woman' relationship includes a challenge to midwives to find ways to embrace uncertainty with women, to communicate that we believe in their expertise and to avoid creating dependencies. The concept is summarised by the use of a metaphor which years later was taken up by Faye Thompson (2004) as depicting the essence of the ethical journey that midwives take alongside women:

The use of metaphor is seen as one of the fundamental building bricks of knowledge ever since Lakoff and Johnson's (1980) ground breaking contention that human thought processes are largely metaphorical (Pearce, 2004). The placing of one set of concepts alongside another can be particularly useful in terms of enabling thought production around the more obscure elements of concepts. In the case of the portfolio text, it is assumed that the reader might be able to identify with both the guide and the travelers in the story of preparing for a journey across rocky, unknown terrain and the subsequent feelings of triumph engendered by the experience. This identification process enables a grasping and reinforcement of the conceptual framework for midwifery that has been articulated throughout the chapter.

Describing the nature of midwifery

> It is only with careful and systematic inquiry about the nature of midwifery care that the profession can clearly define and explicate a model of excellence that can be upheld as a standard for all women. (Kennedy, 2000 p.4)

The notion of 'the less we do the more we give' has been described by Holly Powell Kennedy (2000 p.12) as 'the art of doing "nothing" well'. The work of Kennedy and colleagues in the USA (Kennedy, 1995, 2000; Kennedy et al., 2003; Kennedy, Shannon, Chuahorm, & Kravetz, 2004) plays an important role in contemporary midwifery discourse, in particular the ongoing need to identify the role of midwifery in improving outcomes in maternity care. Their studies provide a

framework for the metasynthesis of qualitative studies of midwifery practice, one that incorporates critical and feminist perspectives in the contextual analyses of how the midwifery relationship with women and childbirth has been, and continues to be, played out.

Whereas the book chapter I wrote presents a highly subjective reflection on midwifery practice, one whose only claim to presenting authoritative knowledge is that of experience and reputation, Kennedy and colleagues engaged in a rigorous research process to illicit the qualities of what it is that is unique and exemplary about midwifery, in particular the 'with-woman' relationship. What is interesting to me is that the conclusions about the nature of midwifery practice in the USA are so similar to those in the book chapter and to descriptions of midwifery in other Western countries, even though the environments and contexts are different. When comparisons are made, the findings in the USA appear to be transferable to other Western countries, in particular European countries, Australia, New Zealand and Canada. This was obvious when Holly Powell Kennedy recently presented her work at the Second International Conference on Normal Labour in England (Kennedy, 2004) to an enthusiastic audience of midwives from the afore-mentioned countries. Kennedy and her colleagues do not presume to suggest that their framework might be used outside of the USA but comparisons with my own work and that of others who have engaged in describing midwifery (Guilliland & Pairman, 1995; Kirkham, 2000; Kitzinger, 1988; J. Sandall, 1995, 1997; Siddiqui, 1991; Thompson, 2004) add weight to the argument that there are indeed a universal set of midwifery values and behaviours that can be articulated and measured.

The first study carried out by Kennedy (1995) used phenomenology to explore the complexities of midwifery practice as experienced by women. The women described a relationship with their midwife similar to that articulated by midwives and women in other countries (Edwards, 2000; Guilliland & Pairman, 1995; Kirkham, 2000; Kitzinger, 1988; J. Sandall, 1995, 1997): a relationship built on respect, trust and alliance that enabled them to direct their care and feel empowered.

Kennedy's second study (2000) used a Delphi method to gain consensus about the elements of exemplary midwifery practice from 52 midwives nominated by their peers as 'exemplary' and 62 recipients of care from these midwives. Three dimensions of practice were revealed: therapeutics, caring and the profession of midwifery. Supporting the normalcy of pregnancy and birth whilst being vigilant and respecting the woman's unique needs formed the basis of the claim that midwifery was the art of doing 'nothing' well.

Kennedy and colleagues (2004a) built on this research by using narrative analysis to interpret stories provided by a purposive sample of 14 midwives and four recipients of care who were a subset of the Delphi study. The three themes that emerged were:

- The midwife in relationship with the woman
- Orchestration of an environment of care
- The outcomes of care, called 'life journeys' for the woman and midwife

Similar themes emerged when Kennedy and colleagues (2003) conducted a metasynthesis of six qualitative studies of midwifery practice in the USA. These findings offer a benchmark and structure for considering the midwifery relationship with women and behaviours that focus on the nature of 'being with' women rather than a set of 'doing to' tasks.

Convincing others of the value of midwifery

> Our computers may rattle through their problems on their way to a certain conclusion. However, when we take time to argue, to deliberate… then we are fulfilling a truly human … side of our natures (Billig, 1996 p.286)

The last three portfolio texts were chosen for how they attempt to persuade others of midwifery's important role. The submission to the South Australian (SA) Nurses Board (NB) responded to legislative reform that wrote midwifery out of all nomenclature in a new 'Nurses Act'. All subsequent documents pertaining to the regulation of nurses and midwives had a footnote stating that midwifery was implied in all references to nursing. The arguments in the submission are designed around 'protecting the public' and are careful to deflect potential accusations that midwives were involved in 'turf war' or professionalising strategies. The submission was written before the ground-breaking work of the Australian Midwifery Action Project was able to provide evidence to back up the arguments presented in the submission regarding how the invisibility of midwifery impedes effective regulation and the protection of the public (Barclay et al., 2003; Brodie, 2002; Brodie & Barclay, 2001).

The Submission to the Senate Inquiry on Public Hospital Funding is included as an example of how continuity of care was being proposed at that time as a cost-effective strategy. In making the case for direct funding for midwives to be Lead Maternity Carers (LMC) as in New Zealand, the submission draws on international, as well as Australian, government documents and reports that have identified the value of midwifery. The fact that these reports are still widely ignored at the time of writing is a reminder of how many barriers there are to midwifery being funded to work according to the potential role identified by the World Health Organisation (1996). The hegemony of private obstetrics in Australia – one third of women have their babies with private obstetricians – plays a significant role in impeding the possibility of direct funding for midwifery in Australia. Evidence generated since the submission was written identifies the high intervention rates associated with private obstetric care in Australia (Roberts, Tracy, & Peat, 1999) and the costs

associated with the initiation of a cascade of obstetric interventions during labour for low risk women (Tracy & Tracy, 2003). However, such evidence is unlikely to affect radical change in public health funding to include midwives as LMCs since obstetric hegemony operates at every level of the systems and ideology that control policy decision-making and public consciousness (Arney, 1982).

Although both these submissions were written with the aim of influencing policy makers, the process of writing these submissions was an important one for the midwives involved – me included - in terms of formulating arguments and learning how to convince others of the value of midwifery. In particular, the discipline of working out the argumentation was an immensely useful and educative process for me as a new Australian and I should pay tribute to Chris Cornwell, Director of the Mothers and Babies Division, Women's and Children's Hospital, Adelaide, who sat alongside me, explaining systems that were unfamiliar. Together we explored arguments and decided which ones were strategic and plausible and which ones should be rejected as potentially alienating to our audience. The subsequent process of sharing the documents with the management committee of the South Australian branch of the ACMI, and their ownership and submission of them, could be seen as a process of rhetorical innovation of immense value in terms of nurturing and building a sense of community. As suggested by Michael Hogan (1998), rhetoric plays an important role in shaping the character, values and health of communities through creating common bonds and a cohesive sense of identity. In this case, the process of coming together to identify arguments was a process of discovery, one that has been described by Herrick (2004 p.19)as 'the most characteristically human activity'. The process of advancing arguments to justify positions and seek to persuade others has an important third arm, that of discovery, inquiry and education for all involved (Herrick, 2004). Thus rhetorical innovation is epistemic for those who are involved in crafting it as well as for those who are the recipients of the arguments that have been created.

Community midwifery

While efforts to convince politicians of the value of midwifery continue to take place across Australia, at a local level, there is a steady increase in the development of midwifery models of care in the public health service in spite of all the obstacles faced by those who advocate for such changes. Midwives and women involved in the politics of birth activism have developed a blue print for the development of community midwifery in Australia: the *National Maternity Action Plan for the introduction of Community Midwifery Services in urban and regional Australia* (Maternity Coalition, 2002). In recent years while working in a practice development role, I developed the conceptual map of Community Midwifery, presented here as a portfolio text, in order to show 'at a glance'

how, where care follows women across the interface of community and hospital services, community-based midwives collaborate with others and spend most of their time out of the hospital. To some extent, it could be seen as a 'vision' document. As identified in the text, in a culture where there is little, if any, funded community midwifery, it is often hard for health care workers and policy makers to conceptualise around anything other than midwives working in hospitals. The map was also intended to encourage midwives and child and family health nurses to explore how they might collaborate more closely, share premises and dovetail their services in the early postnatal period. I have found the map to be a useful tool for describing effective midwifery caseload practice (Leap, 1997c; J. Sandall, 1997) in a model that addresses primary health care principles (Purcal, 1993) and the concept of 'midwifery as a public health strategy' (Kaufmann, 2000, 2002). To some extent it is a visual explanatory metaphor, intended to stimulate the imagination and act as a short cut to understanding (Pearce, 2004).

> Besides being used to convey facts digestibly and encapsulate advice, they [textual graphics] can make quite sophisticated points purely by positioning . (Hicks, Adams, & Gilbert, 1999 p.86).

Engendering conceptual understanding is only one part of a series of strategies to enable the development of community midwifery. The next chapter identifies the efforts of Australian midwives to design education programmes that will prepare them to work in any setting, including community-based models such as the one identified here.

Defining midwifery as we develop woman-centred practice

Nicky Leap
Senior Research Fellow, Midwifery
Flinders University, Adelaide

The midwifery revolution!

- changes that place women at the centre of care

Developments are driving a pragmatic, rather than an ideological, need to articulate midwifery as a separate profession from nursing.

Defining midwifery

- Developing 'direct entry'
- Changing the names of our Schools of Nursing
- Asking the ANF to reconsider its policies
- Challenging State Nurses Acts that render midwives invisible
- Defining midwifery within Nurse Practitioner projects

A personal experience of justifying being a 'non-nurse'

- genuine concerns about safety
- registering as a 'nurse'
- joining a nursing union

In contemporary Australia, both midwives and nurses are developing and identifying their roles.

We need to be able to engage our nursing colleagues in a mutually respectful debate that avoids old-fashioned rhetoric and alienation.

Old fashioned, alienating rhetoric

- "Midwives work with healthy well women and nurses work in a sickness model"
- "Midwives work holistically"
- "Nurses are doctors' handmaidens whereas midwives are practitioners in their own right"

- The bottom line of any rationale for defining midwifery as a separate profession to nursing has to be that we are able to improve outcomes for women and their families

Midwifery, in the sense of 'being with woman' is directly related to the feminist notion of empowerment.

- At every stage of our interactions with childbearing women, as midwives our role is to ensure that women can take up the power that will enable them to lead fulfilling lives as individuals and as mothers.

The relationship that develops between the woman and the midwife... provides the basis of the professional body of knowledge that encapsulates midwifery

This relationship thrives most easily where midwives are able to provide community based continuity of care

There is good evidence to encourage us to develop strategies to enable midwifery continuity of care that focuses on community support

- "When you combine continuity of care with social support from other women, you have a powerful recipe for improving physical and psychosocial outcomes during pregnancy and childbirth for women, children and their partners" (Jane Sandall)

The potential for midwives and women to explore possibilities within the self

- This depends on the midwife being self aware
- It cannot happen where midwives are disempowered

Continuity of care and 'the relationship'

- Within the concept of continuity of carer, this relationship is different from any other relationship that involves health care workers
- the potential for a woman to engage a 'midwife' to be alongside her as she explores how the experience of childbirth impacts on all elements of her life

The 'midwifery overview'

- The midwife works with the woman and her community
- collaborating with other health professionals if necessary
- to ensure a safe and supported transition to new motherhood
- taking into consideration the woman's individual circumstances and wishes

- This is not to deny the important and potentially emancipatory nature of other health professionals' relationships with clients

The embracing of uncertainty together

- Engaging with uncertainty involves profound learning for each individual woman and her midwife in a way that is reciprocal and unique

Women ask midwives to join with them

- To draw on our expertise, experience and knowledge
- to provide them with a safety net
- to be a point of reference in a world where there are more questions than answers

- Recognising and owning our midwifery expertise
- understanding the limitations of our expertise

Informed choice

- The potential for decision making can be biased by the person doing the informing
- There are many situations where no amount of information will clarify the decision process

Midwives' expertise

- Ability to watch, listen and respond with all our senses
- 'cluefullness'
- knowing when to inform, suggest, act, seek help
- when to be still
- when to withdraw and remove ourselves

Our belief in a woman's inherent ability to be her own and her baby's expert should underpin all of our responses

Believing in women

- Making it clear that we have confidence in their potential to
  - monitor their baby's development and wellbeing in pregnancy
  - find a way through pain in labour
  - give birth in spite of any fears or previous traumas

Believing in women (cont)

- Nurture their baby and monitor the baby's wellbeing and development
- listen to their baby's needs and respond according to instinct and commonsense
- make wise decisions in the face of uncertainty, upheaval and exhaustion

Inspiring confidence in women

is often more based in questions than in giving answers

Putting our faith in women gives them powerful messages in labour

- 'midwifery muttering'…'you can do it'
- 'whispered words of wisdom'…'letting it be'...

The midwifery skill of being with women in pain

The ability to be with women in pain and resist the urge to try and take it away

Our understanding of the role of pain in labour

- Inter-related hormonal cascades
- release of endogenous opiates
- promoting a sense of triumph

This increasing awareness around the role of pain in labour is a discreet body of midwifery knowledge that is in direct contrast to the nursing and medical skills of relieving pain associated with pathology

Defining the midwife's role

- The potential for empowering relationships
- The need to welcome the individual skills all of us bring to midwifery

The building of mutual respect between nursing and midwifery will enable all of us to develop and articulate our separate roles in the interests of those for whom we provide care

Chapter 4

Educating Midwives in Australia

The portfolio texts in this chapter allow for a story to be told about radical reform in Australian midwifery education and the development of standards for the midwifery profession. Two key strategies were used in this process: the use of research evidence to demonstrate the need for reform in Australian midwifery education and the formation of a national taskforce committed to raising standards in education, practice and regulation. The portfolio texts are arranged to enable an understanding of how evidence from research strengthens persuasive argument. Their chronological publication order allows for an analysis that demonstrates the increasing confidence of the rhetoric employed. The arguments progress from the opinions and appeals for common sense in a personalised standpoint text to the potent validation of the need for change based on research findings; international compatibility; and the consensus of midwifery leaders from across Australia.

The first portfolio text was published during the early days of my residency in Australia while I was still adjusting to life as an academic and the constraints of systems that identify midwifery as a specialisation of nursing. The tone is that of an outsider who sees fit to comment and as such it is relatively tentative in its appeals for midwives to come together to enable the development of a three year 'direct entry' course:

> ***Portfolio Text 9:***
> Leap, N. (1999) 'The Introduction of 'Direct Entry' Midwifery Courses in Australian Universities: Issues, Myths and a Need for Collaboration'. ACMI Journal of Midwifery. Vol. 12, no. 2, June, pp. 11—16.

This article in the journal of the Australian College of Midwives journal was the precursor to a major project that would change the face of Australian midwifery education. The bringing together of representatives from universities in each state and territory to discuss how to proceed with developing a three-year Bachelor of Midwifery (BMid) is analysed in this chapter in terms of the role of leadership within rhetorical positioning. This initiative led to the formation of the Australian College of Midwives (ACMI) BMid Taskforce that developed standards for the accreditation of three-year BMid programs (Appendix D). In 2004, these standards were identified by the ACMI as the future standards for all midwifery education programs in Australia.

It is proposed that these developments would not have been possible without the evidence generated by the Australian Midwifery Action Project (AMAP), in particular the AMAP Midwifery Education Survey. The AMAP study was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce; regulation; education; service delivery; and midwifery practice issues across the country. During the life of the AMAP project, an extensive literature search on midwifery education was commissioned by the Commonwealth Department of Education, Science and Training (DEST) and the Department of Health and Aged Care as part of the National Review of Nursing Education (Leap & Barclay, 2002). The literature review presented an opportunity to gather evidence that would enable international comparisons in the development of standards that aim to ensure midwives are educated to fulfill their potential role. In turn, the preliminary results of the AMAP Education Survey informed the literature review about the state of midwifery education across Australia.

The following portfolio texts were published in the journal of the Australian College of Midwives. The research presents quantitative and qualitative data provided by the midwifery course coordinators in each university offering midwifery education in Australia. These texts thus enable an analysis of how evidence from research strengthens the rudimentary arguments and appeals of the first text in this chapter:

> ***Portfolio Text 10a:***
> Leap, N. (2002). Identifying the midwifery practice component of the Australian Midwifery Education Programs. Results of the Australian Midwifery Action Project (AMAP) Education Survey. Paper 1. *Australian Journal of Midwifery*. Vol 15. No. 3. Pages 15 - 23.
>
> ***Portfolio Text 10b:***
> Leap, N., Barclay, & Sheehan (2003a). Results of the Australian Midwifery Action Project Education Survey. Paper 2: Barriers to effective midwifery education as identified by midwifery course coordinators. *Australian Midwifery. Journal of the Australian College of Midwives*. Vol 16. No. 3. Pages 6—11.

Portfolio Text 10c:

Leap, N., Barclay, & Sheehan (2003b). Results of the Australian Midwifery Action Project Education Survey. Paper 3: Workforce Issues. *Australian Midwifery. Journal of the Australian College of Midwives*. Vol 16. No. 3. Pages 12 – 17.

In 2002, the introduction of an Australian double degree in nursing and midwifery as an alternative to the BMid prompted the writing of a monograph identifying the issues that raise concern regarding different routes of entry to midwifery. This is included for analysis here because it demonstrates the further strengthening of the rhetorical innovation following the dissemination of the AMAP research; the publication of standards and an information package by the ACMI BMid Taskforce; and the commencement of the three-year BMid in five Australian universities. Like the first text, it is a standpoint text, but the rhetor (me) now writes with confidence on behalf of many. I am now speaking and writing from within a cohesive group with a clearly articulated identity rather than as an outsider testing ideas and searching for those who share common values and ideals.

Portfolio Text 11:

Leap N (2003) Educating Australian midwives: current debates and concerns. Monograph published by the Centre for Family Health and Midwifery, University of Technology, Sydney.

The rhetoric, situations and strategies addressed in these portfolio texts are identified in the framework tables. These issues are explored further as the story from which the texts arose is told in the discussion section of the chapter.

Portfolio Text 9

Leap, N. (1999) 'The Introduction of 'Direct Entry' Midwifery Courses in Australian Universities: Issues, Myths and a Need for Collaboration'. *ACMI Journal*. Vol. 12, no. 2, June, pp. 11—16.

Portfolio Text 10a

Leap N. (2002) Identifying the midwifery practice component of the Australian Midwifery Education Programs. Results of the Australian Midwifery Action Project (AMAP) Education Survey. *Australian Journal of Midwifery*. Vol 15. No. 3. Pages 15 - 23.

Portfolio Text 10b

Leap N, Barclay, L, Sheehan A. (2003) Results of the Australian Midwifery Action Project Education Survey. Paper 2: Barriers to effective midwifery education as identified by midwifery course coordinators. *Australian Midwifery. Journal of the Australian College of Midwives*. Vol 16. No. 3. Pages 6 – 11.

Portfolio Text 10c

N Leap, Barclay, & Sheehan, 2003b. Results of the Australian Midwifery Action Project Education Survey. Paper 3: Workforce Issues. *Australian Midwifery. Journal of the Australian College of Midwives.* Vol 16. No. 3. Pages 12 – 17.

Portfolio Text 11

Leap N (2003) Educating Australian midwives: current debates and concerns. Monograph published by the Centre for Family Health and Midwifery, University of Technology, Sydney.

Discussion:

Educating Midwives in Australia

'It will never happen here in Australia.'

This analysis will examine the rhetorical innovations of the portfolio texts within the context of the story from which they arose. Like the tale of my personal journey to midwifery in Chapter 2, this story tells of a journey. The journey includes my leadership role in the collective action surrounding the introduction of the three year Australian Bachelor of Midwifery and the development of national standards for midwifery education. The increasing confidence of the rhetoric employed in the portfolio texts is linked to the gathering of evidence through research and to the bringing together of Australian midwifery leaders in order to achieve consensus about strategies to improve midwifery education, regulation and practice. The story starts where the Prologue to this thesis ends: 'Thus began my midwifery life in Australia….' I tell it here because it contextualises the environment in which the arguments for the Bachelor of Midwifery took place.

As a midwife who entered the profession via the 'direct entry' route, I encountered many hurdles when attempting to register as a midwife in Australia. I was told that the Australian Nursing Council (the peak regulatory authority) did not recognise my qualification and faced explanations from a series of officials that 'Australia needs midwives who are nurses – it's about safety'. I embarked upon the lottery of finding a state that would register me as a 'nurse', knowing that once registered in one state, the system of mutual recognition would allow me to practise in any other state or territory, as well as in New Zealand. My portfolio, demonstrating over 20 years of experience in midwifery, bulged with examples of practice, references and documents from the UKCC[1]. In New South Wales (NSW), I was told that unless I could produce my personal transcript from my education programme, I stood no chance of registering[2]. The midwifery school, the maternity unit, and the area health authority where I completed my 'training' had all closed down some years ago. If it had not been for the detective work of my daughter – who tracked down the tiny card in a box in the cellar of a university north of London – I would not be able to tell this story.

Once I was given the ironic titles of 'Registered Nurse (RN) and Certified Midwife (CM) in NSW, I registered in South Australia under mutual recognition. Here I was given a laminated A4 certificate stating that I was now a 'Registered Nurse limited to practise midwifery'. Along with those who had

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[1] United Kingdom Central Council for Nursing, Midwifery and Health Visiting: the UK regulatory body

[2] This was particularly galling as I watched a senior academic walk into the 'nurses registration board' and register as a midwife on the basis that she had registered 20 years ago, with no checks on whether she had practised in the intervening years.

been found guilty of professional misconduct or who were registered as being 'physically or mentally incapacitated', I was on the register of 'nurses with limited practising certificates'. This meant that I was not on the Board's mailing list, any correspondence to 'nurses with limited practising certificates' having to be passed in front of the Chief Executive Officer for approval through a process referred to as a 'screen dump'. I discovered this by accident when enquiring as to why I received no mail. My official protestations received a reply confirming this process but blaming it on the limitations of the Board's computer database.

Similar experiences identifying the lack of confidence in 'direct entry' midwives are described in the first portfolio text. These stories shed light on the resistance to the efforts of those of us who were starting to introduce the concept of a three year Bachelor of Midwifery. Repeatedly, I was told that the BMid would never happen in Australia due to the needs of rural communities and concerns that midwives are only safe practitioners if they are nurses. Even after the first BMid curricula were being developed in South Australia (SA), such opinions were identified publicly by the State Secretary of the South Australian branch of the union for nurses and midwives, the Australian Nurses Federation (ANF). The article was entitled, 'ANF continues to oppose direct entry midwifery' and pledged to members that it would 'continue to oppose the introduction of direct entry courses…'

> The ANF has a national policy, which opposes direct entry education for specialist areas of practice such as midwifery and mental health nursing…
> We believe that it is necessary for nurses to undertake a broad-based undergraduate program and to specialise at postgraduate level.
> This is particularly relevant in the contemporary environment where clients' needs are so diverse and nurses must be able, more than ever before, to respond to the full range of needs… direct entry midwifery courses are not in the best interests of the community or the nursing profession (Gago 2000:2).

Within this climate, I was extremely tentative when writing the journal article. Criticism of the education system had to be incorporated in the argument in such a way that it would not alienate the reader. It therefore draws on the arguments of one of Australia' prominent midwifery educators in criticising current inconsistencies in standards (Glover, 1999). The effort to highlight the need for change [criticise] whilst engendering collective action was a major challenge for a newly arrived outsider, aware of the justifiable resistance to the arrogant complaints of 'whingeing Poms[3] from the Mother Country'[4]. The journal article therefore appeals for a coming together of those who share common concerns with the writer. This appeal identifies evidence from relevant literature but

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[3] 'Whingeing Poms: Australian slang for those coming from the UK who complain about life in Australia, making constant comparisons with the 'mother country'. 'Pom' or 'Pommie' originates from the convict title: 'Prisoner of Mother England'.

[4] I was further cautioned when one of the referees for the journal article responded with similar indignation and an outraged tone; the other referee's comments were full of encouragement and constructive suggestions.

also draws on the somewhat tenuous ‘discussions with women, midwives and nurses from around Australia’ as well as my contacts with midwives in other countries and my personal experiences. The article adopts a story telling, simple style intended to appeals to the values, experiences and aspirations of those motivated enough to read the journal of the Australian College of Midwives. It assumes a commitment and motivation to make changes happen that will improve the standards of Australian midwifery education. Whilst identifying midwifery as a separate profession to nursing, the article attempts a respectful positioning around the excellent reputation of Australian nursing education and the decisions that the nursing profession will make if direct-entry trained midwives wish to undertake a Bachelor of Nursing in order to obtain dual qualification.

The development of the three-year Bachelor of Midwifery in Australia

Echoes of the rhetoric in the journal article with its proposed strategies for collective action resonate in the story of the development of the Australian Bachelor of Midwifery. Soon after the article was published in the ACMI journal, the Victorian branch of the ACMI published a booklet that added considerable weight to the arguments in my text. *Reforming Midwifery: A Discussion Paper on the Introduction of a Bachelor of Midwifery into Victoria* (ACMI Victoria, 1999) made the case for three year programs that would enable graduates to develop and work in midwifery continuity of care models. Whereas my journal article could be seen (and dismissed) as the opinions of an ‘outsider’, the ACMI Victoria booklet was significant in terms of raising awareness that the BMid was an initiative that was being promoted by Australian academics and practitioners in at least one state. For the first time, people began to take the introduction of the BMid seriously. This led to a flurry of outrage and anxiety as evidenced in the following quote from the Federal Secretary of the ANF. The author refutes the rhetoric regarding the rationale for an Australian BMid (as evidenced in the first portfolio text) as the opinions of a minority group. Whilst stating that there are ‘other ways’ to address the issues’ there is no elaboration of these:

> The ANF does not support direct entry midwifery programs. There are many arguments put forward in support of direct entry programs – that they are necessary to address the midwifery shortages; address deficiencies in current midwifery education; are necessary for the introduction of new models of midwifery care; are necessary in order to provide the highest quality maternity care; and, follow a world-wide trend in midwifery education. One of the difficulties in accepting these arguments is that they do not acknowledge that these issues can be just as effectively and more economically addressed in other ways… The view that the ANF holds is one, which is determined through consultation with the membership through the branches. The view seeks to be representative of all members, not just reflective of the views of a few… (Iliffe, 2000 p.1).

The development of a collaborative initiative to introduce and develop standards for the Australian BMid has been described by Thorogood, Pincombe & Kitschke (2003). The initiative to develop a national taskforce for the introduction of the Australian BMid began in South Australia (SA), where

I held a post at Flinders University. The appeals I had made in the journal article for a concerted effort and unified approach were taken seriously by the Deans of both 'nursing' faculties in Flinders University, Adelaide and the University of South Australia. Both universities were committed to a 3-year Bachelor of Midwifery but decided to delay commencement until other universities could start courses at the same time. As identified in my recently published journal article, it was felt that this would maximise support for the students/new graduates, would establish the BMid as a serious mainstream option and prevent marginalisation of the courses in a potentially hostile climate. There was also recognition that it was important to prepare the way for the introduction of the BMid by raising awareness of the issues. The negotiations that led to this holding back exercise were complex and sensitive. They took place in a competitive culture where individuals prioritised secrecy and a drive to be 'the first' university to start a BMid over the sharing of ideas and resources and collaborative effort. However, the meetings that began to take place between midwifery academics in the two universities would eventually lead to a joint Course Advisory Committee to steer the introduction of three-year Bachelor of Midwifery programs in the two universities. The meetings also led to the national collective action that I had been advocating for in the rhetorical positioning of the introduction of the BMid.

The SA universities employed a Project Officer who contacted universities across Australia to establish a register of interested parties. From this list, key midwifery educators from each state and territory were invited to a meeting in Adelaide. A facilitator (funded by the SA Universities) skilfully enabled consensus decision-making about the way forward. The outcome of the meeting was a commitment to proceeding as an Australian College of Midwives Taskforce and to develop national Standards for the Accreditation of the BMid. The aim was to enable the development of courses across Australia within a similar framework and to achieve comparable outcomes, which could be evaluated. Information was distributed widely through the 'BMid Newsletter' and a database of potential students was set up. In the interest of promoting an inclusive approach, an advertisement was placed in the ACMI Journal calling on universities to lodge expressions of interest regarding the introduction of a BMid. Attention was drawn to publications that would inform all key stakeholders about the initiative (ACMI Victoria, 1999; Fraser, Murphy, & Worth-Butler, 1997; N. Leap, 1999a; Radford & Thompson, 1988).

Coming together for collective action: the ACMI BMid Taskforce

Universities across Australia began to explore the potential of forming a consortium or partnership approach to developing BMid programs. Meanwhile, the ACMI continued raising the issue with relevant organisations across Australia and I began to coordinate the ACMI National Bachelor of Midwifery Taskforce. It is interesting to note that in New Zealand, the pressure group of consumers and midwives who campaigned for direct entry midwifery education also called themselves a 'taskforce'. The word is reclaimed from any military connotations and suggests collective action – or joining forces - around a common task; as such, it suggests both strength and purpose.

The ACMI BMid Taskforce members made a commitment to representing their states/territories and to ensure that information concerning the BMid was both gathered and disseminated at a local level. This included holding public forums and engaging with universities, health services, regulatory bodies and consumers. The taskforce engaged in a process of consensus decision making during our bi-annual meetings as well as in a process of circulating and re-circulating all documents via the Internet for comment and editing. These email rounds continued until all parties were prepared to sign off on the documents. In this way, the *ACMI Standards for the Accreditation of Three-year Bachelor of Midwifery Education Programs* were developed (Appendix D). In my leadership role as Convenor of the taskforce, I was supported by a group of midwifery leaders, most of whom were committed to the concept of 'woman centred care', the exploration of power relationships and feminist process. All meetings started with a feminist 'round' where each woman was assured of confidentiality and given space to talk about what was going on in her life – at home and at work – if she wanted. We made a conscious effort to listen to each other; to avoid situations where any one individual dominated; and to respect different opinions but be open to 'persuasion'. The common values and goals enabled this approach as well as extraordinary bursts of activity and commitment to making change happen.

As a group chosen for their known expertise and political positioning in midwifery, it was relatively easy to lead the group employing the collective action principles that arose from the Women's Liberation movement of the 1970s and 1980s (see Chapter 2). Eva Cox (1996) has written about women's uneasy relationship with leadership. She makes a plea for moving away from narrow definitions of leadership and for feminist ways of leading that involve power sharing:

> The onus of responsibility can be legitimately shared in ways which give us credit for skills and recognise diversity without hierarchy. Sharing the burdens and responsibilities also means sharing the fun of being effective (Cox, 1996 p.256).

This quotation from Eva Cox sums up the success of the BMid Taskforce where shared responsibility engendered a sense of fun in the relatively laborious tasks of pouring over every word of documents until consensus was achieved.

A sense of 'sisterhood' was also developed with a panel of international midwifery education experts from Canada, the United Kingdom and New Zealand. These midwifery leaders offered support for the introduction of a BMid in Australia. They shared their countries' experiences of developing similar programs and had an ongoing role in reviewing the *ACMI Standards for the Accreditation of Bachelor of Midwifery Courses* and related policy and curriculum documents. Notably, they verified that the standards were compatible with those of their country and that Australian graduates meeting these standards would be unlikely to have to engage in further education in order to register in their countries. This was an important issue when promoting and justifying the introduction of the Australian BMid as can be seen in the rhetoric of the portfolio documents in this chapter.

As well as developing the *ACMI Standards for the Accreditation of three-year Bachelor of Midwifery Education Programs* (Appendix D), the ACMI BMid Taskforce devised an information package in the form of a PowerPoint presentation with notes in hard copy as well as on CDRom (Appendix E). The aim was for all branches of the ACMI to give the presentation in as many venues as possible. The information package was designed to support an extensive process of consultation with users and providers of maternity services, professional organisations and regulatory authorities. It was proposed that this process of consultation and information sharing would help engender support for student placements and assist in the process of registering graduates of the courses.

The rationale for the introduction of an Australian Bachelor of Midwifery (BMid) was presented in terms of the overall aim of the ACMI to increase the number of competent midwives and midwifery graduates in all areas of Australia: 'the bottom line for any developments has to be improvements to the services offered to childbearing women, their families and communities'. However, the information package identifies far more than this rhetorical identification of the rationale for the introduction of the BMid: it is saturated with the rhetorical positioning of midwifery in the Australian context. The development of the BMid enabled an opportunistic appeal to key stakeholders around the following themes:

- The need to develop national standards for midwifery education embedded in regulation
- The identification of midwifery as a discreet profession in its own right, separate from nursing
- Appropriate education to enable midwives to work in continuity of care models according to the international definition of the midwife

- International trends in midwifery education and the evaluation of programs in the UK and NZ
- Addressing midwifery workforce shortages
- Australian midwives must complete further studies and/or midwifery practice placements in order to register in other western countries.

Midwives who are not nurses: addressing concerns

The concerns and misconceptions about the BMid that are identified in the journal article were addressed in the *ACMI BMid Information Package*. The PowerPoint slides and notes (Appendix E) demonstrate how the midwifery leaders in the ACMI BMid Taskforce chose to portray the issues following extensive discussion and a process of arriving at consensus over every word in the document. This process allowed for a more sophisticated and confident version of the rhetoric previously employed in my preliminary discussion of the issues in the first portfolio text. On reflection, the journal article I wrote in 1999 was successful in its rhetorical intent. It enabled collective action around the development of a three-year 'direct-entry' program in Australia; it also provided a platform for the rhetorical strategies that were employed to justify the new educational programs and address common concerns and misconceptions. When writing the original journal article with a degree of trepidation, I could not have predicted the success of its strategic intent. However, the rhetoric employed in the early days of the ACMI BMid Taskforce was about to be strengthened considerably by a major research project studying Australian midwifery.

The Australian Midwifery Action Project Education Survey

The Australian Midwifery Action Project (AMAP) was funded by the Australian Research Council. The project had an overall aim to investigate the service delivery, education, policy and regulatory environments affecting midwifery in Australia. The goal was to provide information to assist industry partners, health departments, health services, universities and regulatory bodies to improve maternity care. The project analysed the barriers to safe and cost-effective midwifery care and examined the problems of communication and co-ordination across these sectors (AMAP, 2003). The AMAP researchers worked as a group rather than accepting that one 'best person' has sufficient knowledge or is free from personal or professional idiosyncrasy. Findings from the empirical data generated by AMAP were thus integrated with our own different opinions, backgrounds and experiences. This process has been described as 'synthesising judgement'; a necessary step in making high quality decisions in the absence of certainty and evidence from randomised controlled trials (Black et al., 2001).

My initial role with the project was as an investigator from Flinders University in South Australia. Later, after moving to Sydney, I was employed as a researcher to lead the AMAP Education Survey. The three portfolio texts reporting on the findings of the AMAP Education Survey are analysed together for their contribution to rhetorical discourse regarding Australian midwifery education. This research was crucial in identifying the 'realities' of the situation regarding midwifery education in Australia through an analysis of the data provided by the course coordinators in each university providing a program for qualified nurses wishing to become midwives.

The findings and recommendations of the Education Survey were outlined by Professor Lesley Barclay in her Executive Summary of Volume 1 of the AMAP Report (AMAP, 2003 p.10-11) and can be summarised thus:

- When considering workforce requirements and program development, providers of midwifery education must address the current and future needs of women.
- There is no overall consistency in the design, duration or level of award both nationally and within each separate state/territory.
- Many programs appear deficient in clinical experience for students.
- There is no national monitoring system to guarantee comparability or an adequate baseline of theory, competence or award nomenclature.
- Standards are not compatible with those of international midwifery education programs, particularly in relation to the length of courses, and therefore Australian midwives have to undertake further education if they wish to practise overseas.
- The ACMI demonstrated excellent national professional leadership in facilitating consensus from expert educators on the standards required to enter midwifery practice with regard to international compatibility.
- Regulatory authorities should adopt these standards for all programs
- With the transfer of midwifery education to universities, health services reduced their responsibility for student learning as their budgets for this responsibility were removed.
- Supernumerary status appears to exacerbate the separation of the education program from industry involvement in some jurisdictions, perpetuating economic hardship and a fragmented service for women.
- There are particular problems related to recruitment and retention when addressing the needs of rural Australia, especially those of Indigenous communities.
- National research is needed to investigate, monitor and evaluate the introduction of the BMid and the double degree in Nursing and Midwifery.

In presenting the 'realities' of Australian midwifery education through the findings of the AMAP Education Survey, the three portfolio journal articles link the findings to the familiar rhetorical concepts associated with woman centred care outlined in previous chapters. In this case, the rhetoric addresses the assumed common aim to educate midwives who can practise with confidence and competence, providing continuity of care to women across the interface of hospital and community settings. The rhetorical positioning appeals for midwifery being a discrete profession in its own right, as opposed to a 'specialisation of nursing'. Unlike the first journal article in this chapter, which relied on my opinions, the rhetorical positioning in these three articles is reinforced through evidence from research. The identification of barriers and strategies to effective midwifery education in Australia belongs to those leading the programs and thus the rhetoric has a strength that was missing in the earlier work.

Review of midwifery education for the National Inquiry into Nursing Education

At the same time as I was engaged in the AMAP Education Survey, I was the first author of a review of midwifery education commissioned by the Department of Education, Science and Training (DEST) as part of a National Inquiry into Nursing Education. The review included the preliminary findings of the AMAP Education Survey and an extensive literature search drawing on databases, policy documents, research and other resources, in collaboration and with assistance from national and international experts (Leap & Barclay, 2002).

An extensive, focussed, literature search on midwifery education in the UK, Canada, New Zealand, Netherlands and the USA (drawing in particular on MIDIRS searches specific to these countries) was made. The researchers' private collections of relevant documentation, much of which was gathered during educational visits to these countries, also informed the initial search. Midwifery education experts from each country were identified through already established networks, several of them having already provided information and advice to the ACMI Bachelor of Midwifery National Taskforce. The contributors were Tina Heptinstall (UK); Anne Nixon (Canada); Beatrijs Smulders (the Netherlands); Sally Pairman (New Zealand); and Holly Powell Kennedy (USA).

These international experts were informed of the purposes of the Review, and were invited to comment on an initial draft of an overview of midwifery education and development in their country written by myself after a search using the MIDIRS database. They were asked to confirm that key issues relating to midwifery development and education in their country were adequately and accurately addressed and to identify any sources of unpublished literature or literature that had not been accessed in the initial search. The international experts were asked to address the themes

identified by DEST for the Review, in particular issues relating to standards for midwifery education and the development of these in each of their countries. Their modification of the documents enabled international comparisons to be made.

The review of midwifery education identified that a 'levels of evidence' approach to assessing the quality of literature presumes 'objectivity' that is only possible in the presence of high quality empirical data. As in health care itself, there are many areas 'where sufficient research based evidence may never exist. In such situations the development of guidelines will inevitably be based partly or largely on the opinions and experience of … [those] with knowledge of the subject at issue' (Black et al., 2001). The researchers made the case for a synthesis of empirically derived data and consensus development derived from expert opinion. Those who contributed to the review were recognised as 'experts' by the professional community in a number of countries by bodies such as the World Health Organisation, national and state governments, and international midwifery associations.

The literature review and data generated by the review made an important contribution to the analysis and recommendations of the AMAP Education Survey. In particular, the opportunity to make national and international comparisons added strength to the rhetorical positioning of the research, which made a coherent case for the introduction of the BMid across Australia. Evidence from other countries, in particular the UK, guided the arguments employed as well as the processes involved in convincing others of the value of a three year undergraduate midwifery degree as a major strategy to improve the standard of midwifery education and practice across Australia.

Midwifery and Nursing: assumptions of inclusivity

The Centre for Family Health and Midwifery successfully tendered to carry out the Review of Midwifery Education identifying the correct assumption that the National Inquiry into Nursing Education would see midwifery education as falling within its brief. In Australia, there is a frequent dilemma regarding whether to engage or reject projects where there is an assumption that midwifery is part of nursing and where midwifery is rendered invisible in nomenclature. At the time of writing, the Nursing Education Taskforce that resulted from the Inquiry into Nursing Education is asking the midwifery profession to participate in the rolling out of the recommendations of the Inquiry. This offers an example of the dilemma. In spite of providing the comprehensive literature review, including the preliminary findings of the AMAP education survey, and in spite of formal requests for inclusivity in nomenclature from the AMAP researchers following the draft report of the Inquiry, midwifery is not included in the recommendations, all of which refer only to 'nursing' and 'nurses'. The recommendations from the midwifery literature review were ignored. An informal

conversation with one of the key organisers of the Inquiry identified that in the consultation process that took place around Australia, nurses expressed contradictory points of view about midwifery from those in our review, particularly regarding the development of the BMid.

Where nursing sees fit to lead policy recommendations on behalf of midwifery and where midwifery is neither fully included nor presumed to require its own arena and platforms, important issues are raised concerning power and control. As was explored in Chapter 3, the exclusion of midwifery nomenclature renders midwifery invisible within nursing and this has particular implications for the development of policy, regulation and standards that protect the public (Bogossian, 1998; Brodie & Barclay, 2001). The ACMI was one of the industry partners of the AMAP research. Bolstered by the evidence from research, the College began a concerted effort to develop an integrated set of standards for the profession of midwifery and to form partnerships with nursing organisations. It was envisaged that the rhetorical promotion of collaboration and changes in nomenclature would enable a shift of power and control away from nursing so that these standards could be governed by the ACMI (Brodie & Barclay, 2001).[5]

The monograph: contextualising the arguments

Within a climate of increasing solidarity in Australian midwifery following the AMAP research, the final portfolio text in this chapter was written. The impetus was to make a response to increasing concerns that many Australian midwives and nurses were embracing the double degree in Nursing and Midwifery as the ideal solution for the Australian context. Information gathered through informal networks, the ACMI and the BMid Taskforce suggested that universities were encouraging their staff to develop the double degree in preference to the BMid. The rationale for this thinking is included in the paper alongside a strong argument of an opposing view: one that advocates for the BMid as a more appropriate alternative. The Centre for Family Health and Midwifery at the University of Technology decided to publish the paper as a monograph in order to hasten its dissemination in the national arena and to enable the promotion of discussion at an ACMI Education Forum.

The monograph was chosen for inclusion here because it demonstrates my increased confidence as a rhetor arguing for improvements in the standards of midwifery education to meet the needs of childbearing women in Australia. Evidence from national and international research, policy documents, the National Maternity Action Plan (Maternity Coalition, 2002)[6] and consultations with

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[5] The most recent of these changes occurred in 2004 when the peak body for state and territory 'nursing' regulatory authorities changed its name to the Australian Nursing and Midwifery Council.
[6] The National Maternity Action Plan was developed by users of maternity services to articulate the need for wide-spread, publicly funded, community based midwifery continuity of carer.

midwifery experts are synthesised in a measured attempt at persuasion. The rhetorical concepts and suggested strategies are much the same as in the other portfolio texts in this chapter, but the arguments and appeals are made by one who is now an accepted insider rather than the newly arrived outsider of the first text, which was published four years earlier. The presentation of information includes a summary of opposing positions, in particular the arguments in favour of a double degree in Nursing and Midwifery. Questions are posed that invite responses from midwives who are assumed to want international compatibility, midwifery models of care and a strong midwifery (as opposed to nursing) identity. Respect is paid to those who work in both roles in rural and remote areas but the emphasis is on exemplary education systems and standards in both professions.

The ACMI National Education and Standards Taskforce

In 2003, the ACMI BMid Taskforce was disbanded and a democratic selection process took place to enable representation from each state and territory in a new taskforce. I was elected to chair the inaugural ACMI National Standards and Education Taskforce (ANEST). This group develops standards and position statements for the ACMI using the same consensus building techniques as those employed by the ACMI BMid Taskforce. One of the first crises that the new taskforce had to negotiate was a heated debate regarding an ACMI Position Paper that stated the College's opposition to the notion of a double degree in nursing and midwifery. This position paper was challenged as divisive and unwise through a motion at the 2003 Annual General Meeting. The motion was unsuccessful but a commitment was made to re-write the statement on midwifery education. A successful rhetor in the new ANEST group managed to persuade the rest of the group to think laterally about the double degree. She assured us that the graduates of these programs would meet the *ACMI Standards for the Accreditation of three-year BMid Programs.* The ensuing debate prompted a major shift in thinking during meetings and email conversations throughout 2003 and the first half of 2004. The *ACMI Standards for the Accreditation of three-year BMid Programs* were finally adopted as the *ACMI Education Standards for Midwifery Education* with an aim for these to be the standards of all programs leading to initial license to practise midwifery in the future, regardless of routes of entry to the profession. The rhetoric in the new position paper is one of inclusivity with the setting of standards acting as a leveller.

ACMI Position Paper: Midwifery Education (2004)

The ACMI recognizes multiple routes of entry into midwifery and values graduates from all programs. The ACMI strongly supports the establishment of undergraduate midwifery programs.
The ACMI recognizes that midwifery and nursing are distinct professions each with its own philosophy, ethics, body of knowledge and scope of practice. The discrete and independent nature of the profession of midwifery is fundamental to all curricula that lead to registration as a midwife. Midwifery curricula must enable students to acquire the knowledge, skills and attitudes necessary to practise to the full role and scope of midwifery as defined by the ICM/FIGO/WHO (1992). Programs of midwifery education must therefore reinforce and promote the recognition of midwifery as a separate professional identity.

The theoretical and clinical practice components of all midwifery programs are underpinned by the ACMI Framework for Midwifery, which incorporates the:

ACMI Midwifery Philosophy
ACMI National Code of Ethics
ACMI National Standards for Midwifery Practice
ACMI National Midwifery Competencies
ACMI National Midwifery Guidelines for Consultation and Referral
ACMI Standards for Midwifery Education
ACMI Framework for Continuing Professional Development

The ACMI is committed to collaborating with regulatory authorities on the accreditation of all midwifery education programs conducted in Australia.
The ACMI promotes and expects all midwives as part of their professional obligations to engage in regular, relevant and high quality ongoing education and practice, supported by the ACMI Framework for Continuing Professional Development. (ACMI 2004)

The process of arriving at this position paper can be seen as one of testing and refining ideas through rhetorical discourse. The motivation was the perceived need to respond to a series of overlapping and interwoven situations. A sense of community through coming together and working towards consensus positions and standards was employed and is evident in all of the texts analysed here. The ACMI Standards for Midwifery Education (2004) provide a suitable place to conclude the story that has been told in this chapter.

RESULTS OF THE AUSTRALIAN MIDWIFERY ACTION PROJECT (AMAP) EDUCATION SURVEY.

PAPER 1: IDENTIFYING THE MIDWIFERY PRACTICE COMPONENT OF AUSTRALIAN MIDWIFERY EDUCATION PROGRAMS.

Nicky Leap RM, MSc (Midwifery)

ABSTRACT

This paper is the first in a series of papers reporting on the findings of the AMAP Education Survey of the 27 universities providing a program for initial authorisation to practise midwifery. It concentrates on issues related to the practice component of courses[1]. Subsequent papers will present findings related to workforce issues and the barriers to effective midwifery education as identified by the midwifery course coordinators.

Serious concerns are raised about the standards of Australian midwifery education, particularly when international comparisons are made, in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice across community and acute settings.

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[1] In terms of nomenclature, and in the interest of clarity and consistency, midwifery education programs are generally referred to as 'courses' throughout this paper since this was identified as the most common terminology in use when designing the questionnaire and during the telephone interviews. Similarly, the words 'clinical practice' are used here with recognition that the Australian college of Midwives has a commitment to use the words 'midwifery practice' to more accurately reflect the role of the midwife (ACMI Draft Standards for the Accreditation of three year Bachelor of midwifery Programs).

INTRODUCTION

In 2001, researchers at the Centre for Family Health and Midwifery, University of Technology, Sydney undertook a survey of midwifery education as part of the Australian Midwifery Action Project (AMAP).[2] The aim of this study was to describe the current position of midwifery education across Australia, as identified by the midwifery course coordinators in each university offering a program for initial authorisation to practise midwifery. Until recently, all midwifery education in Australia has been through postgraduate nursing courses. Data regarding the three-year Bachelor of Midwifery courses that started in four universities in 2002 and the double-degree (Nursing/Midwifery) course that commenced in one university in 2001 were not included in this survey.

In order to provide a national profile of midwifery education in Australia and develop recommendations, a range of issues were compared such as course demographics, prerequisites, minimum theory and practice hours of education, practice supervision and teaching processes. In line with the AMAP research questions, the study also explored the course coordinators' views of the barriers to effective midwifery education and strategies to overcome these barriers.

BACKGROUND

The quality, nature or process of education of midwives has not been seriously studied in Australia for nearly two decades. During this period, programs have moved from hospital locations and teaching to universities. The hospital programs and their regulating framework of the 1970s and 1980s were recognised as highly problematic in terms of the quality of education (Barclay 1986) but, despite this, recent shifts in education have not been managed, monitored or evaluated.

Since Barclay's 1986 thesis, concerns regarding inconsistencies across states and territories and barriers to appropriate midwifery education and regulation have continued to dominate discussions (Hancock 1992, Barclay 1995, 1998, Barclay & Jones 1996, Bogossian 1998, Waldenstrom 1996,1997, Leap 1999, Glover 1999, ACMI Victoria 1999, Tracy et al 2000, Brodie & Barclay 2001, Leap & Barclay 2002). Serious concerns have been expressed about Australian midwifery education when international comparisons are made, particularly in relation to preparing competent, confident midwives who are able to meet the challenges of contemporary midwifery practice and innovative changes in maternity service provision (Waldenstrom 1996, 1997, Leap 1999, Leap & Barclay 2002).

In New Zealand, Canada, the United Kingdom and other European countries, the dominant form of preparation for practice is through three and four-year midwifery courses rather than routes that require students to be nurses first. There is a move towards nurses having to undertake at least two years of full time study in these three and four year programs in order to gain sufficient experience of midwifery practice.

METHODOLOGY

Using a structured questionnaire and undertaken primarily using telephone interviews, a survey was administered to all 27 universities offering a midwifery course leading to initial authorisation to practise as a midwife. Following ethics approval, the study commenced in May 2001 and data collection was completed in February 2002. The research was undertaken on behalf of AMAP by various researchers with different roles. The researcher who conducted the interviews collated and coded the data and presented it in a blended, de-identified format to the AMAP researchers for analysis.

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[2] [2] The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce, regulation, education, practice and service delivery issues across the country.

FINDINGS

Specific findings related to the clinical practice component of courses are represented here under relevant headings.

Mode of study and length of course

A variety of modes of study were identified with the majority of courses [16] running internally although seven universities offered an external mode of study. Four other universities offered both modes of study. Six universities offered only part-time midwifery education courses, two offered only full time study and the rest offered both full time and part time study modes [Table 1]. Based on enrolments in 2001, the number of students studying part time was 563 compared to 375 students enrolled in full time study.

Course coordinators were asked to describe the length of their courses based on full time study. This was problematic for the six who only offered part time courses; some of these gave estimates based on full time study, others gave the actual length of their part time courses. The length of courses for all those who offered a full time study mode included two academic semesters of approximately 13 –14 weeks each (n=21). Some course coordinators identified only the academic year as the length of their course. Others specified that the length of the course around these two semesters ranged from approximately nine months to 12 months (n=9) in order to include clinical practice placements [Table 1].

Theory hours

There was considerable variation in the number of theory hours identified by course coordinators ranging from 174 to 2, 160 hours with the majority (19) having less than 400 hours. Course coordinators who reported large theory hours in their courses appear to have based this figure on expectations of student initiated activity in courses offered externally.

Clinical practice hours

The number of hours allocated to clinical practice also differed greatly between courses, as did the ratio of theory to practice hours [Table 1]. The range described by the course coordinators was between 500 and 1824 hours with the majority (16) less than 1000 hours. Table 1 identifies the variations in length of courses by mode, full time and part time status of students and the ratio of theory to practice components in courses.

Table 1: Midwifery education programs by mode, full time/part time and supernumerary/employed status of students, length of program and numbers of clinical practice and theory hours as described by midwifery course coordinators

Internal External mode	Fulltime [f/t] Parttime [p/t] Both [f/t & p/t] Supernumerary S Employed E #	Length of program [based on f/t study unless stated otherwise]	Clinical practice hours	Theory hours
Internal	f/t S & E	Full 12 months	1200	224
Internal	Both S & E	Full 12 months	Supernumerary: 900 Employed: 1212	247
Internal	Both S & E	Full 12 months	1130	224
Internal	Both E	Full 12 months	1600	364
Internal	Both S & E	Full 12 months	Supernumerary: 440 Employed only: 440 +5 shifts per fortnight	916
Internal	Both S & E	Full 12 months	832	252
External	Both E	Full 12 months	1824	954
External	Both S & E	Full 12 months	1032	1560
Both	Both S	Full 12 months	760	174
Both	f/t S & E	45 weeks	Supernumerary 640 + 2days wk salaried Employed: 925	222
Both	Both S & E	45 weeks	1078	286

Internal	Both S	1 year *	528	276
Internal	Both E	I year: March to January	1056	180
both	Both S & E	Supernum.: 32wks Employed: 48 wks	Supernumerary: 1000 Employed: 1450	340
External	Both S	1 year: March - December	800	600
Internal	Both S & E	1 academic year	656 min Supernumerary: 2 days/wk or equivalent Employed: 5 shifts/fortnight	312
Internal	Both S	1 academic year	600	400
External	Both S	1 academic year	600	312
Both	both	2 semesters March - Dec	780	312
External	Both S	2 semesters March - Nov	888	Unable to say
Internal	Both S	28 weeks	500	320

Courses offered in part time mode only

External	p/t S & E	Full 12 months	800	unanswered
Internal	p/t E	12 months	1660-1692	256
Internal	p/t E	3 semesters (p/t)	1008	960
Internal	p/t S (1st yr) E (2nd yr)	42 weeks	750-900	398
Internal	p/t E	4 semesters (p/t)	1800	384
External	p/t E	64 weeks (p/t)	800-1040	180 per unit - total 2,160

* In some cases it was not made clear whether 'a year' was an academic year of two 13 –14 week semesters or a full 12 months.

Some courses offer a combination of supernumerary and employed experience. Where there are two separate models this is made clear in the clinical practice hours column.

Clinical practice placements

Clinical practice placements occurred in different modes: weekly, block, yearly and sometimes a combination of these. Seven courses combined supernumerary and salaried experience, five courses offered either a supernumerary or employed option, eight offered supernumerary experience only and seven offered a salaried model only for clinical practice placements [Table 1]. Rates of pay for those who were in the salaried model varied and respondents identified this as an important issue that needs to be addressed. Students in nine courses were paid as RNs at their level of experience/service in nursing. Examples of other arrangements ranged from individual negotiations with employers (3) to being paid at 'Level 1 RN' regardless of the student's experience in nursing (3).

Students undertaking supernumerary placements were allocated fewer clinical practice hours than those in models with a paid component [Table 1]. This factor was directly related to the financial burdens on students described by midwifery course coordinators and the fact that many students continued to work as nurses throughout their education in midwifery.

Difficulties in organising placements

Course coordinators highlighted particular difficulties in arranging clinical placements. This restricted the number of places they were able to offer to students.

In the majority of courses students were particularly disadvantaged by not being able to access clinical placements that reflect contemporary maternity service developments, in particular, placements in the community and in midwifery models of care.

Clinical support and supervision

Over half of the university staff involved in teaching midwifery are not involved in supervision and assessment in clinical areas. Course coordinators highlighted difficulties experienced by students in clinical practice placements that may contribute to attrition rates, both during their education and on graduation. These included the impact of a lack of 'ownership' by hospital staff of the need to provide support and supervision for students. The under staffing of areas where students were

placed, stressful working environments and horizontal violence compounded these difficulties for students.

Minimum clinical practice requirements to gain the award

The course coordinators generally referred the researcher to their local regulatory authority, usually referred to as the 'Nurses Board' regarding minimum clinical practice requirements. Those that offered a full explanation highlighted the differences that exist between state and territory standards in relation to the minimum practice requirements of midwifery education programs (Brodie & Barclay 2001).

Types of facilities used by the students for clinical practice placements

Students were required to rotate through hospital areas and in some cases through different types of hospitals in order to meet the course accreditation requirements of the local nursing regulatory authority. As identified by Brodie and Barclay (2001), these requirements vary considerably from one state/territory to another. Rotation was most often driven by the need for students to have experience in tertiary referral centres and Level II nurseries. All but one respondent [26] stated that they used tertiary level hospitals for midwifery clinical practice placements. With only a few exceptions, most courses also used regional or rural hospitals, some specifying that these facilities had to have a Level II nursery. In all but three courses, private hospitals were used for clinical placements, with four respondents clarifying that they only used private facilities to access experience for students in postnatal areas. Students placed in private hospitals needed to rotate into public hospitals in order to access sufficient experience of attending women labouring and giving birth.

One respondent identified that competition between universities for clinical practice placements in the same facilities forced students to rotate through different hospitals. In comparison, one respondent identified a system where it was compulsory for students to remain with the hospital to which they were assigned for the total duration of their midwifery education.

Some regulatory authorities did not require midwifery students to engage in any community based placements. Eleven courses did not enable students to have placements in areas other than hospital wards. Table 2 identifies areas where students may have been able to gain 'community experience' in the 16 courses that offered this opportunity.

Table 2. Summary of identified community placement areas used in midwifery programs (number of courses = 16)

Placement area	Number
Elective time with independent midwife/midwives	[6]
Maternal and Child Health Centres/Early Childhood Nurse	[5]
Community midwifery program	[3]
Women's Health Centre	[3]
Family Planning/Sexual Health Centre	[2]
Community Centre/ Support group	[2]
Mother and Baby Unit/Residential Care for PND Unit	[2]
Postnatal 'early discharge' program	[1]
'Urban Community Nurse'	[1]
Overseas placement	[1]
'Community placement – e.g. Birth Centre'	[1]
Reproductive Medicine Unit	[1]
Medical Practitioner's Rooms	[1]
Elective in rural hospital	[1]

Course coordinators identified difficulties in obtaining placements where students would gain experience in specific areas considered to address contemporary issues in midwifery practice as identified in Table 3. While the theory component of these practice areas was covered in courses, on the whole, placements in such areas were electives that the students had to organise and fund themselves. Course coordinators expressed frustration regarding the fact that placements were limited to care in hospitals within the confines of a one year program. Difficulties identified with

placing students in rural and remote maternity services included the pressure to meet clinical requirements in areas where maternity service provision is occasional or low volume.

Table 3: Opportunities for clinical placements

Placement area	Placement offered	Elective option*	Not offered
Rural and remote maternity services	13	3	11
Aboriginal and Torres Strait Islander Health	8	7	12
Cultural diversity in midwifery care	21	1	3
Continuity of care models	17	6	4
Following women through	23	2	2
Birth centre care	14	8	5
Home birth	4	12#	11

* Elective option includes where course coordinators identified that it depends on whether the hospital the student is placed in offers this experience. It also includes situations where the student organises this experience (as opposed to the education provider).
# Placements with midwives providing home birth services were identified as rare, and almost always organised and funded by the student.

Clinical practice placements: supervision and assessment

In most programs, responsibility for the organisation of clinical practice placements rested with the university. There were only five examples reported where hospitals and universities liaised closely in organising clinical practice placements. In some cases, before commencing their midwifery education program, students had to secure a placement with a hospital themselves and then have it approved by the university. In three instances the students were interviewed by the hospitals of their choice.

Arrangements for supervision and assessment varied considerably. The researchers had difficulties in identifying these arrangements with titles such as 'university staff', 'lecturer', 'mentor', 'preceptor', 'lecturer practitioner' 'clinical educator' and 'joint university/hospital appointee' being used interchangeably by some respondents to describe university and hospital staff positions.

Difficulties experienced by students in clinical placements

Participants were asked to list the difficulties or problems experienced by their students on clinical placement. While it was recognised that not all students experienced problems the following nine themes were consistently identified as causing problems for students:

- Lack of support /supervision
- Horizontal violence
- Rostering issues
- Learning needs of the students are secondary to the hospitals needs
- Staffing issues
- Philosophy conflict
- Competing demands
- Placement difficulties.

These issues will be discussed fully in the second paper of this series, which identifies the barriers and strategies to midwifery education as described by the midwifery course coordinators.

DISCUSSION

The AMAP Education Survey confirms concerns expressed by others regarding a lack of consistency in the duration or design of midwifery education programs, both nationally and within each separate state/territory (Hancock 1992, Chamberlain 1998, Glover 1999a, 1999b, Tracy et al 2000). An absence of midwifery specific regulation regarding standards for the accreditation of programs has led to these inconsistencies (Brodie & Barclay 2000).

In the last decade, new models of maternity care have been developed in Australia and overseas in response to changes in government policies and the identification of strategies to better meet the

needs of childbearing women (Tracy et al 2000, NHMRC 1996). According to Page (1997:5), 'the basis of these reforms in all countries is the provision of appropriate education and preparation for modern day midwifery practice'. In Australia, as elsewhere, midwives are licensed and therefore must be prepared at a level that enables them to function as practitioners in their own right, without having to undertake further education or training. According to the international definition of a midwife (WHO 1966), graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise. This role is described in many Australian midwifery curriculum documents. However, the short length of courses when compared with other countries, the identified need for graduate midwifery programs and the notion of preparation for a 'beginning practitioner' (Glover 1999a) suggest that many Australian midwives may not be adequately prepared to work autonomously, without further midwifery practice experience. This is paradoxical and concerning given that midwives are licensed to provide care in their own right following initial registration (Chamberlain 1998, Leap & Barclay 2002).

The AMAP education survey highlights inconsistencies in the minimum practice requirements of Australian midwifery education programs. Whilst most states require proof of achievement of both competencies and minimum practice requirements, in some states competency based assessment is the only requirement. The way this is implemented gives cause for concern. There is the potential for a situation where a preceptor could determine that a student is 'competent', even though the student has attended a minimal number of births. Glover et al (2001: 433) cite an example where a student could not get employment in her country hospital on completion of her midwifery education 'as she did not have enough experience as a midwife'.

In reviewing midwifery in Australia when in her role as Professor of Midwifery at La Trobe University, Ulla Waldenstrom (1997) outlined developments, such as continuity of care models and birth centre care, which give cause for optimism about the future. She identified that the challenge is to change mainstream care in the public sector and that education needs to be expanded to facilitate these changes. Waldenstrom suggested benchmarking standards with countries like New Zealand, the USA, Canada and the European Union, a process currently being employed by the Australian College of Midwives, Inc. As an illustration she listed the clinical requirements for midwifery qualification of the 15 countries of the European Union where the recommended length of midwifery education for nurses is at least 18 months, full time.

The maximum number of births that Australian midwifery students are required to participate in is twenty. Brodie and Barclay (2001: 106) point out that all current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries. They cite as an example the requirement in Europe for midwives to participate in at least 40 births and in Canada 60 births, before receiving registration. Brodie and Barclay (2001) also point out that in the United Kingdom, Canada and New Zealand, regulatory Boards use agreed national criteria to accredit, not only curricula, but also teachers, facilities and services. In these countries regulatory frameworks ensure that theory and practice are integrated in equal proportions in programs and that adequate staff to student ratios are maintained in clinical areas. Australian midwives are seriously disadvantaged when they wish to work abroad and often have to complete further education and training, particularly in community midwifery (Leap 1999).

In other comparable western countries, midwifery is being promoted as a public health strategy to address health inequalities (RCM 2000a, 2000b). Currently, the potential for students in Australian midwifery courses to gain experience in this role is limited with eleven courses not providing students with placements in any areas other than hospital wards. 'Community placements' in some other courses included 'a reproductive medicine unit', 'medical practitioner's rooms', 'a birth centre' or 'an elective in a rural hospital'. Clearly, any placement other than a hospital ward is being defined as 'community' making it hard for students to gain any understanding of primary health care principles in action. Instead, Australian midwives are being educated for an acute care role in the

majority of courses and are not exposed to experiences that might foster an understanding of their potential role as primary care providers based in the community. Students need to learn to work with medical and allied health colleagues, and community services in a different role from that adopted as a midwife (or nurse) in a hospital team. Furthermore, the current indemnity insurance crisis has led to a situation where some midwifery students and their university lecturers are prohibited from practising in any areas other than in public hospitals under 'supervision'. This has serious implications for educating future practitioners to provide continuity of care to women across the interface between hospital and community settings.

Midwifery course coordinators lamented the lack of opportunities for students to participate in midwifery models, including birth centre care in hospitals. National and international research has demonstrated that where midwives are able to respond to the identified needs of women and provide a personal and continuous service through pregnancy, birth and the early weeks thereafter, they report an increased sense of satisfaction and autonomy (Sandall 1996, Stevens & McCourt 2002). Furthermore, the experience of working in such models of care may transform approaches and attitudes to practice (Brodie 1996, Homer et al 2000, Kenny et al 1994, McCourt & Page 1996, Page 1995, Rowley et al 1995, Waldenstrom and Turnbull 1998, Stevens & McCourt 2002). Midwifery students, who are exposed to this way of working, even if only in theory, find the tensions between such models and the realities of tertiary midwifery services in Australia discouraging (NSW Health 2000). Concerns about the mismatch between ideology and the realities of mainstream maternity service provision were expressed in this study. These concerns have been explored by Barnes (1997), who describes Australian midwifery students struggling to develop a 'woman centred' approach to care in the light of the increasing medicalisation of childbirth, in particular, rising epidural and caesarian section rates. Across the western world, the increasing use of technology in childbirth and escalating caesarean section rates limit the opportunity for students to learn about normal childbirth (Davies 1996, Hunt 2000).

This study raises debate about the experience of students who do not have a paid component in their midwifery practice placements. Some midwifery educators have advocated for students to have supernumerary status in order to avoid situations described in studies by Begley (1999a, 1999b) in Ireland, by Chamberlain (1997) in the south of England and by Barclay (1985) in Australia. In these studies, students described seeing themselves as part of the workforce and believed that their educational needs were denied. Much of their learning took place by 'trial and error'. As in this study, the importance of mentorship or preceptorship in clinical areas was highlighted. However this study suggests that supernumerary students may be seriously disadvantaged compared to those with employed status, not only in terms of financial discrimination, but also in terms of less clinical practice experience. Australian midwifery students in supernumerary placements have fewer hours in practice areas and fewer opportunities to be immersed within a midwifery practice environment. Course coordinators identified that many experience fragmented placements in different hospitals where they are not necessarily seen as 'part of the team' and are therefore marginalised. The nature of supernumerary placements also contributes to the lack of incentive on the part of hospitals to provide adequate numbers of placements for midwifery students.

The AMAP Education survey has demonstrated that almost two-thirds of students in Australian midwifery education programs are engaged in part-time study and continue to work as nurses throughout their midwifery education. In our data, part time study appeared to be problematic, prolonging time to graduation and preventing genuine participation in maternity service provision. Given the time from commencement to completion, the linking of theoretical and practice learning seems serendipitous rather than planned or productive. Glover (1992, 1999a) has advocated strongly for part-time midwifery education in Australia. Part-time study is not an option in three and four-year programs in Europe although various reports (ARM 1999, UKCC 1999) suggest that this should be considered in the future. In reviewing midwifery development in Canada, Tyson (2001) suggests that part-time study should be phased out, as it is inappropriate for primary care provider programs. She identifies that part-time study increases attrition and distraction of focus for students

and that it takes many years to develop a midwifery identity. She questions the quality of clinical learning when there are long periods of time between introductory subjects and practice subjects and suggests that part-time study contributes to the problem of insufficient midwifery workforce numbers.

According to the midwifery coordinators in this study, part-time study and supernumerary status are directly related to the financial hardship of midwifery students. Midwifery in Australia is classified as a postgraduate qualification that builds on a nursing qualification therefore it often attracts full course fees. The financial constraints for nurses of undertaking midwifery education were described as also contributing to recruitment and attrition rates. Some supernumerary midwifery students are obliged to continue working as nurses throughout the period of undertaking midwifery education. For some this means full time employment as a nurse and fitting in midwifery placements whenever possible. This factor is clearly stressful and militates against quality midwifery education and a sense of midwifery identity. The problems associated with students fitting full-time study and midwifery practice placements around continued full-time employment as nurses were alluded to by Glover et al (2001) and were identified as a major problem by midwifery course coordinators in this study. Students who are employed and who are supported by health service employed educators do not report these problems.

CONCLUSION

This study raises serious concerns about the standards of midwifery education when international comparisons are made, particularly in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice. It is crucial that full engagement and partnership be developed between universities, health services and clinicians to resolve the ownership of, and responsibility for, practice based education and move Australian midwifery education towards internationally recognised best practice.

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RESULTS OF THE AUSTRALIAN MIDWIFERY ACTION PROJECT (AMAP) EDUCATION SURVEY.

PAPER 2: BARRIERS TO EFFECTIVE MIDWIFERY EDUCATION AS IDENTIFIED BY MIDWIFERY COURSE COORDINATORS.

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ABSTRACT

This paper is the second in a series of three, reporting on the findings of the AMAP Education Survey. It concentrates on the barriers to effective midwifery education as identified by the midwifery course coordinators from the 27 Australian universities providing a midwifery program for initial authorisation to practise as a midwife

In line with the major research questions of the Australian Midwifery Action Project (AMAP), the midwifery course coordinators were asked to identify what they saw as the barriers to providing quality midwifery education and strategies to overcome these barriers. Their main concerns centred on the difficulties in providing appropriate clinical practice placements, financial pressures for students and barriers to effective teaching and learning. Mostly the strategies were a reversal of the identified barriers. These findings highlight the need for major reform in the way midwifery education is organised and funded in Australia.

INTRODUCTION

In 2001, researchers at the Centre for Family Health and Midwifery, University of Technology, Sydney undertook a survey of midwifery education as part of the Australian Midwifery Action Project (AMAP 2003)[1]. The aim of this study was to describe the current position of midwifery education across Australia, as identified by the midwifery course coordinators, in each of the 27 Australian universities offering a program for initial authorisation to practise as a midwife. The three-year Bachelor of Midwifery courses that started in four universities in 2002 and the double-degree (Nursing/Midwifery) course that commenced in one university in 2001 were not included in this survey.

The first paper in this series (Leap 2002), presented the background to the study and issues related to the practice component of courses[2]. Serious concerns were raised about the standards of Australian midwifery education, particularly when international comparisons were made, in terms of the length of courses, clinical practice requirements and the opportunities for students to engage with contemporary midwifery practice across community and acute settings. This paper presents the midwifery course coordinators' views regarding the barriers to midwifery education and strategies to overcome these barriers. The third and final paper will identify workforce implications highlighted by the study.

METHOD

Following ethics approval, the study commenced in May 2001 and data collection was completed in February 2002. A structured questionnaire was undertaken largely using telephone interviews (four respondents chose to complete the questionnaire and return it by mail), surveying all 27 Australian universities offering a midwifery course leading to initial authorisation to practise as a midwife. The research was undertaken on behalf of AMAP by various researchers with different roles. One researcher (AS) conducted the interviews and then collated and coded the data and presented it in a blended, de-identified format to the other AMAP researchers (NL & LB) for analysis.

In line with the major research questions of the Australian Midwifery Action Project (AMAP), the midwifery course coordinators were asked to identify what they saw as the barriers to providing quality midwifery education and strategies to overcome these barriers. These were listed by the interviewer during the telephone interviews or collated in the instance of mailed questionnaires. Together with a question eliciting problems experienced by students in clinical practice areas, these de-identified data formed the results that are presented in this paper. The analysis was made using simple thematic groupings and content frequency.

FINDINGS

The main concerns identified by the midwifery course coordinators centred on barriers associated with providing appropriate clinical practice placements (68), financial pressures for students (24) and teaching and learning difficulties (18)[3].

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[1] The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia and strategies to address these barriers. This included studying workforce, regulation, education, practice and service delivery issues across the country.

[2] In terms of nomenclature, and in the interest of clarity and consistency, midwifery education programs are generally referred to as 'courses' throughout this paper since this was identified as the most common terminology in use when designing the questionnaire and during the telephone interviews. Similarly, the words 'clinical practice' are used here with recognition that the Australian College of Midwives has a commitment to use the words 'midwifery practice' to more accurately reflect the role of the midwife (ACMI Draft Standards for the Accreditation of three year Bachelor of Midwifery Programs).

[3] Numbers in brackets represent the number of times an issue in this category was listed by the midwifery course coordinators.

Barriers associated with providing appropriate clinical practice placements (68)
Midwifery course coordinators saw difficulty in securing placements as a major barrier to quality midwifery education, with inadequate collaboration and communication between universities, hospitals and health services cited by many. There were reports of prospective students and university staff receiving a poor reception and even hostility when trying to organise placements. Competition for places between universities was identified as especially acute where students were not employed and where midwifery staff were preceptoring other health workers, for example, ambulance personnel, medical students, nurses and rural midwives on exchange programs. In some hospitals, placements were limited by a policy of having only one student per shift in each area, particularly where students were supernumerary.

Rural students were seen to be particularly disadvantaged in terms of clinical placements. They often needed to travel long distances to tertiary units in order to gain a range of experiences, with the ensuing hardship in terms of cost, time and distance from families. Where students were able to secure placements in rural and remote units, they often needed to spend large amounts of time during their midwifery education working as nurses, looking after patients in general wards.

Some midwifery course coordinators described having little control over the planning of placements with resulting difficulties in ensuring that theory and practice were integrated. They perceived the organisation of midwifery education in universities as contributing to the widening of the 'theory/practice gap'. Poor communication between hospital and university staff and the lack of strategic systems for funding and organising midwifery education and the supervision of students compounded this:

> *Even where hospitals make a commitment to quarantine money for students this does not always happen… Funds are redirected away from students*[4].

Midwifery course coordinators consistently expressed concern about the lack of midwifery models of care to enable students sufficient experience to become competent, confident practitioners according to the full potential of the midwife's role. In many areas there was insufficient exposure to systems that provided 'woman centred care', team midwifery, birth centre experience, community placements and cultural diversity:

> *The curriculum may promote midwifery models of care, but the reality that students confront on placement is usually very different.... The culture of the hospital environment is not conducive to midwifery.*

Some stated that the fragmented models of care in maternity units mirrored nursing models rather than midwifery models. The perceived focus on '*sickness and interventions*' was seen to reinforce students' previous experience in nursing and their tendency to seek and prioritise medical, as opposed to midwifery, knowledge.

The medicalisation and privatisation of childbirth in Australia, with high intervention rates and *'very little normal midwifery'* was highlighted in the midwifery course coordinators' comments. Some bemoaned the fact that obstetricians and GPs received funding to provide care for women who were 'low risk' and that midwifery education was poorly resourced when compared to medical education. There was frustration with the government's apparent prioritising of doctors' needs and perceived lack of commitment to developing and funding midwives as primary care givers for the majority of women throughout their experience of pregnancy, labour and the early postnatal period. In spite of government recommendations (NHMRC 1998), midwives were still unable to order and interpret tests and have limited prescribing rights. Area health services were not seen by some to be implementing the strategic planning for maternity services that had been identified to address many of these issues.

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[4] Direct quotes are presented throughout this paper in italics.

Staff shortages in hospitals were cited as the reason for inadequate supervision of students in a culture of increased workloads, poor support from managers, double shifts, an increasingly casualised workforce and evident 'burnout'. There were reports of experienced midwives being unable to provide continuity and engage with the activities in the students' learning guides and portfolios because they were too busy. Low morale in units and many instances of horizontal violence, hostility, unrealistic expectations and poor support for students were also described.

Many of these concerns regarding clinical placements were reiterated in a separate question in this study, where participants were asked to list the difficulties or problems experienced by their students on clinical practice placement. While it was recognised that not all students experienced problems, nine themes were identified as causing problems for students:

- Lack of support/supervision
- Horizontal violence
- Staffing issues
- Competing demands
- Rostering issues
- Learning needs of students secondary to hospital needs
- Philosophy conflict
- Placement difficulties
- Unrealistic expectations of students

Table 1 provides examples of responses that fit within each of these themes.

Table 1: Difficulties experienced by students in clinical placements as identified by midwifery course coordinators.

Lack of support/supervision (15)
Some students don't feel well supported by midwives. This could be because the midwives are unable to interpret the competencies at a beginning level, but it's also because of the large numbers of casual staff and the inability to get a regular preceptor.
Questioning can make some midwives feel threatened that the student is challenging their knowledge base and so that leads to reluctance to teach.
Because students are supernumerary there is a cultural perception that they are not part of the organization
There are difficulties related to responsibility and partnership. Hospitals have a situation where there are a multitude of students and the preceptors don't do what is expected of them even though they are given an outline of their role.

Horizontal violence (13)
Students are treated fairly poorly. For example, they are put down, their skills are not valued, it's made difficult for them to ask questions, and they are ridiculed in front of patients.
The socialization in the midwifery clinical area, for example, bullying and harassment are the greatest causes of dissatisfaction.
Some students feel that they are picked on and treated rudely; no credit is given for them being an RN

Staffing issues (12)
The hospitals are short staffed which leads to large workloads for the students, for example, eight women plus their babies can be allocated to one student midwife.
Hospitals being short-staffed means that experienced midwives are unable to help and also to sign off activities in the student portfolios because they are too busy.
All units are stressed because of staffing problems. Staffing levels are unrealistic; staff morale is low which contributes to their behaviour.
There is competition with other students from other health disciplines, for example ambos and doctors

Competing Demands (9)
They have to work as nurses while also trying to complete their studies and midwifery practice placements.
They need to work elsewhere to make ends meet and they burnout with having to meet the demands of study, finances and family.
There is no funding for the release of students for clinical placements and residential learning schools.
The greatest cause of attrition rates is the supernumerary aspect of clinical, which causes financial constraints.
Distance is a problem –many students live a long way away from clinical placements

Rostering issues (8)
There is inflexibility over hours and placements, often due to the constraints on hospital staff, for example, there are limited staff who are preceptors and other students are also needing attention.
Rostering problems include them being rostered on university days and also put on night duty the night before, also split days off (using them as fill-ins).

Learning needs of the students secondary to hospital needs (6)
There is tension between students' needs and service needs particularly when students first start employment. As their learning needs decrease this isn't as acute.
The hospitals don't bond with the university. They feel they are ultimately responsible to the patient and so the student always comes a long second.
Supernumerary students feel exploited whereas paid students don't.

Philosophy conflict (5)
The philosophy of the agency differs from that of the university. It's the medical model versus a woman centred approach.
There are difficulties contracting available quality experiences. There is so much intervention; the students are not seeing so much of the normal. It's getting harder to find quality experiences with fewer interventions.
There is a yawning chasm between what they learn in regards to midwifery models and what they see in the hospitals.

Placement difficulties (5)
Placements themselves are difficult; every university does different models of clinical, for example, two out of three tertiary hospitals may be directly linked to the university, which means the other universities cannot get into the hospital to get clinical placements. If they do get in they just get the crumbs, therefore it's not the best educational experience for the students.
Some universities use salaried models some don't. Salaried students get preference. Students from universities with exclusive agreements with hospitals get preferential treatment over other students because they are paid although they do the same work. Students feel they are treated differently.

Unrealistic expectations of students (3)
Clinicians are not sure of what students should be able to do. They have high expectations of them, even on their first clinical placement.
Students are left in situations they shouldn't be in and asked to do things they shouldn't do, but students can also cause problems. After limited theory and no clinical experience, they can challenge everything.

Barriers associated with financial pressures for students (24)
Financial hardship for students was seen as a major barrier to recruitment and retention and one respondent stated *'Students who have left the course because of financial constraints have expressed their desperate situation.'* A lack of financial support led students to undertake part time midwifery courses and some took several years to complete. Many students continued to work as nurses throughout their midwifery education, some full time, as they had no other source of income: which as one participant stated *'is very demanding and confusing and doesn't consolidate learning adequately'*. Even when students had access to the Higher Education Contribution Scheme (HECS), midwifery education usually involved a loss of earnings, plus expenses associated with additional fees, books and travel. Inflexibility about how and where students were able to do their placements compounded the difficulties experienced by rural and remote students in some cases.

Barriers associated with teaching and learning in midwifery education (18)
The commitment of preceptors and hospital staff to midwifery education and support was seen as lacking with some midwives being unwilling to be preceptors or to engage in teaching, often because of their lack of experience in teaching. There were suggestions that some practising midwives had a resistance to university education and a lack of understanding of the importance of knowledge development in educating midwives to be practitioners in their own right.

One year was seen as limited time in which to prepare midwives for practice. Midwifery course coordinators identified that, within universities, midwifery was still seen as a specialty of nursing and the particular requirements of midwifery as a separate discipline were not addressed or

funded. It was described as inappropriate to place midwifery programs in postgraduate nursing degrees, *'the requirements of midwifery are different… [Midwifery Education is] much more intensive and yet it is still a post graduate degree locked into 12 months when it would be better over at least 18 months'*. Some expressed concerns about having insufficient time to address the fact that nurses have been *'socialised into a nursing model'*.

Regulation was identified as a barrier to midwifery education, with the accreditation of midwifery programs subsumed within inappropriate nursing regulatory frameworks that did not match academic accreditation processes or foster innovation. Most midwifery course coordinators described nursing education priorities taking precedence in universities and regulating bodies, and situations where decisions have not necessarily reflected professional midwifery or maternity services needs.

Strategies to overcome barriers

Course coordinators identified that systems change needed to happen at the top level of administration, funding and policy development in health departments, universities and service provision. The perception was that this would alleviate the breaking down of lower level agreements and promote collaboration and commitment between all parties concerned with midwifery education.

Strategies associated with clinical practice placements

A key strategy was the development of more collaboration between all stakeholders to increase the number of appropriate clinical practice placements for students and promote joint 'ownership' of planning and organisation. This would include devising systems to fund university support for preceptors and educators. The idea of seamless integration of teaching by academics and clinicians was proposed, where academics would have the right of access to hospitals and where clinicians would lecture students and be involved in overall assessment. Structures to support this would include ongoing education and support for both university staff and clinicians. Regular meetings were seen as a strategy to improve communication and promote equal opportunities for all students. Stronger affiliations were advocated to prevent the *'under cutting'* related to competition for placements. There was a suggestion that the planning of multidisciplinary student placements could be a collaborative venture with regard to prioritising opportunities for flexible and block placements. Most course coordinators favoured the option of paid employment for students but some advocated funding to enable full time students to have supernumerary status in clinical practice areas.

An increase in publicly funded midwifery models of care was seen as one of the most pressing strategies to promote quality education programs. The following quotation encapsulates the tone of much of the data:

> *More midwifery models of care need to be established and funded. I wish to stress that I mean midwifery models, not maternity models. The two major criteria are continuity of care and midwifery led care, not obstetric led care.*

One respondent suggested that there needed to be a *'massive publicity campaign that encourages midwives to nurture the up and coming generation of midwives'*. Others suggested campaigns to raise the profile of midwives in the community and promote midwifery models of care. There was a plea *'not to set students up as change agents'*, political activity for change being seen as the responsibility of individual midwives and the Australian College of Midwives, Incorporated (ACMI).

Strategies to promote teaching and learning

The three-year Bachelor of Midwifery was identified by a third of the respondents as an important strategy to address many of the barriers to midwifery education, and to enable midwifery to be recognised as a profession in its own right by universities. One respondent, though, had concerns about midwifery education *'separating from nursing'* and thought that a four-year double degree, *'a nursing degree with an extra year endorsement as a midwife'* was a more appropriate way forward.

There was some support for extending the length of the program to at least 18 months duration with several course coordinators advocating that one year or more of that time should be in full time, paid employment in a maternity unit. Several respondents advocated flexible learning, using web-based materials and computer skills courses for students and staff. Again, collaborative approaches to teaching and learning between university staff and clinicians, with funding for joint appointments, were identified as important by most respondents. This would involve clarifying the teaching and learning model, in particular the skills, competency and capabilities of midwives who facilitate practice. Some respondents thought that all midwives should be supported to teach students as part of their professional responsibility, whereas others thought that it was important to release designated educators to spend time with students in clinical practice areas.

Strategies to relieve student financial hardship

An employment model was seen to assist students with finances as well as *'enabling a sense of them belonging in clinical practice areas'.* Funded placements, scholarships, HECS arrangements and subsidies were suggestions for funding arrangements with an emphasis on extra funding for travel, accommodation, support and flexible learning for rural and Indigenous students. Funding arrangements to make it easier for students to study full time were seen as beneficial in terms of enabling students to focus on midwifery and not nursing during their education.

DISCUSSION

Two major themes underpin the responses of Australian midwifery course coordinators regarding barriers to midwifery education: the culture of the workplace in which students learn the practice of midwifery and the move of midwifery education to universities. Many of these issues have been discussed in the first paper in this series, notably the length of courses; financial burdens for students; restricted access to midwifery models of care; the nature of part-time study and supernumerary placements; lack of adequate support and supervision for students; and restricted practice placement opportunities (Leap 2002).

The problems identified here by midwifery course coordinators mirror many of those described by Australian midwives in another AMAP study (Brodie 2002). Midwives who were asked to identify barriers to midwifery service provision, spontaneously identified midwifery education issues as vitally important. They expressed concern about the quality of new graduates and the difficulties of creating a supportive teaching and learning environment in under staffed, medicalised environments.

As identified elsewhere (Bosanquet 2002, Fraser 2002), the culture of hospital maternity services has a profound impact on the effectiveness of student learning and the perceptions of midwifery students as to whether they are accepted as members of a team. Staff shortages, horizontal violence, conflicting ideology, escalating intervention rates, stress and poor morale are dominant forces in obstetric driven maternity units where students spend most of their clinical placements (Ball et al 2002, Brodie 2002, Cavanagh & Snape 1997a, 1997b, Kirkham & Stapleton 1999). As few as a quarter of women give birth without interventions of one sort or another in many obstetric units (Downe et al 2001, Johanson et al 2002,). Serious questions need to be asked about the quality of experience available to students, particularly in terms of their capacity to learn about normal birth (Bosanquet 2002, Davies 1996).

Several studies have highlighted the need to support and nurture student midwives in order to address the potentially stressful nature of their experiences, particularly around the hostility of qualified staff (Begley 1999a 1999b, 2001, Chamberlain 1997, Jackson 1995, NSW Health 2000a, NSW Health 2000b, Yearley 1999). An attitude of respect for students and a breaking down of oppressive hierarchical structures are essential factors if we are to produce caring midwives in the future and respond to childbearing women's identified needs (Begley 2001). Effective midwifery education depends on experienced, enthusiastic mentors being available in adequately staffed areas, committed to changing the working culture as well as forging good links between staff in

universities and practice areas (Gould 2003, UKCC 1999). The importance of developing community based, midwifery models, where students can engage in woman centred, primary health care approaches to midwifery practice, should not be underestimated (ARM 1999, Davies 2001, Homer et al 2001).

For teachers of nurses and midwives, the loss of identity with the health service and the difficulty in maintaining links and clinical competence when trying to establish programs within a university setting have been well described by Barton (1998)[5]. Furthermore, it appears that midwifery course coordinators in this study did not see themselves as sufficiently powerful to 'override' school of nursing priorities in programs or claims on resources. Although there were problems when hospitals had ownership of midwifery education, they invested heavily with skills and resources to ensure workforce and clinical competency requirements were met (Barclay, 1986, 1995, 1998). The strategies proposed by the midwifery course coordinators to address these problems would be facilitated by regulatory changes that would oblige all key stakeholders to work together in addressing education and practice standards (Brodie & Barclay 2001), workforce requirements and recruitment and retention strategies (AHWAC 2002). Such changes may need to address the midwifery course coordinators' concerns about the length of courses, particularly considerations of international compatibility and the issues associated with introducing three year undergraduate degrees in midwifery and double degrees in nursing and midwifery (Leap & Barclay 2002, Leap 2003).

CONCLUSION

The midwifery course coordinators in this study articulated a clear understanding of the barriers affecting midwifery education and a significant commitment to articulate and engage in strategies to address these problems. Suggestions included increased collaboration between universities and service providers, addressing regulatory frameworks and the seamless integration of teaching by academics and clinicians. There was support for extending the length of programs to include a strong, funded clinical practice component with extended placements in midwifery models of care and the community.

As advocated by the Commonwealth Inquiry into Nursing Education (DEST 2002), a full engagement and partnership should be developed between universities, health services and clinicians to resolve the ownership of, and responsibility for practice based education[6]. There is an urgent need to address serious problems evident in the current system, to develop funding mechanisms that relieve student financial hardship and promote community based midwifery models as the most appropriate learning environment for students. These issues will be explored further in the third paper in this series, with reference to recruitment and retention and the workforce crisis facing Australian midwifery.

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[5] The AMAP Education Survey demonstrated that over half of the university staff involved in midwifery education were not also involved in clinical practice supervision

[6] Midwifery was not identified separately in the recommendations of the Commonwealth Inquiry into Nursing Education, thus it is important to determine whether recommendations apply to midwifery education equally, in part, or not at all. Note: The authors of this paper were commissioned to write a review of midwifery education with international comparisons for the Commonwealth Inquiry into Nursing Education:
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Educating Australian midwives: current debates and concerns

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Abstract

This discussion paper highlights current debates concerning the appropriate way(s) to educate Australian midwives so that they are confident and competent to work according to the full potential of the midwife's role. International comparisons are made when considering programs for nurses who wish to become midwives as well as the new midwifery education programs being introduced to Australia: the three year Bachelor of Midwifery and the four year Double Degree in Nursing and Midwifery.

Introduction

In the last decade, new models of maternity care have been developed in Australia and overseas in response to changes in government policies and the identification of strategies to better meet the needs of childbearing women (Tracy et al 2000, NHMRC 1999). According to Page (1997:5), 'the basis of these reforms in all countries is the provision of appropriate education and preparation for modern day midwifery practice'. In Australia, as elsewhere, midwives are licensed so they must be prepared at a level that enables them to function as practitioners in their own right on graduation, without having to undertake further education or training. This means that graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise. This paper explores some of the issues associated with preparing midwives for this role and draws on the midwifery education survey carried out by the Australian Midwifery Action Project (AMAP 2002).

New midwifery models in Australia

The 'New Models of Maternity Service Provision: Australian Midwifery Perspectives' conference held in 1998 in Adelaide could be seen as a turning point in contemporary Australian midwifery development. Hosted by the Women's and Children's Hospital and Flinders University, Adelaide, the conference brought together midwives from across Australia to showcase the innovative projects that were offering women midwifery continuity of care. Several of these had been established for a few years as a result of the Commonwealth Alternative Birthing Services funding but the majority of projects were in their infancy. The atmosphere at this conference was one of highly charged expectation. It seemed as though Australian midwifery was on the brink of fundamental changes and that the recommendations of government documents, such as the 1996 NHMRC *Options for Effective Care in Pregnancy and Childbirth*, would be implemented.

In the last five years, progress has been slow but midwifery models including team midwifery and caseload practice have continued to be developed in Australia. Recently, organised consumer demand for midwifery continuity of care has been articulated in *The National Maternity Action Plan* (NMAP 2002) and in campaigns to replicate the successful midwifery run free-standing birth centres of other countries (Rooks et al 1992; Waldenstrom et al 1997; Saunders et al, 2000), particularly in areas where small maternity units are facing closure.

In light of such changes, many midwives have been considering how best to prepare midwives for the full potential of their role. Where midwives provide continuity of care, they 'follow' individual women across the interface between hospital and community services. They need to work in a different role from midwives who work in one area of hospital based maternity service provision - such as antenatal clinic, delivery suite, birth centre, postnatal ward or early discharge program – often referred to as providing 'fragmented care'.

Midwifery education in other countries

In other comparable western countries, midwifery is seen as a distinct profession, with its own discreet body of knowledge, and not as a specialisation of nursing. Most midwives graduate from three and four year 'direct entry'[1] (DEM) programs. The minimum length of courses for qualified nurses

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[1] In order to make international comparisons, the term 'direct entry' midwifery (DEM) will be used here. Australian midwives prefer to refer to a 'Bachelor of Midwifery' (ACMI Victoria). Since this is not necessarily a recognised term for courses for initial authorisation to practise midwifery in other countries (for example, many of the programs in the UK are Diploma courses) the term DEM will be used to avoid confusion whenever it applies to other countries.

wishing to become midwives is 18 months. However, there is a move towards nurses undertaking at least two years of the three and four year DEM education programs in order for them to gain sufficient experience of midwifery practice (UKCC 1999, correspondence with midwifery educators in NZ).

European countries such as France, Germany, Denmark, Belgium, Switzerland and the Netherlands have continued to develop three and four-year programs as the only route of entry to midwifery ever since midwifery was regulated in those countries during previous centuries. In New Zealand (NZ) and Canada, the development of DEM education programs was chosen following legislation that enabled autonomous, publicly funded midwifery services (Tulley 1999, Tyson 2001). As in the United Kingdom (UK), - where over 80% of midwives are now educated through three and four year programs - DEM education was developed in NZ and Canada following research identifying this as the most appropriate way to prepare midwives for their full potential role (Radford and Thompson 1988, Tulley 1999, TFIMO 1987). Rigorous evaluations of DEM education programs in other countries have been encouraging, particularly in terms of recruitment and the education of competent, confident midwives, capable of providing continuity of care in all settings on completion of study (Kent et al 1994, Fraser et al 1998, New Zealand Ministry of Health 1995, Kaufman et al 2001a, 2001b).

Wherever governments enable women to have publicly funded continuity of midwifery care, DEM education is regarded as the most appropriate form of education for midwives. This is because it allows at least three years of concentration on midwifery theory and practice in equal proportions and enough time for students to gain plenty of experience of midwifery in both hospital and community settings. Study of at least three years duration is seen as the way to prepare graduates who, on point of entry to the profession, are safe, autonomous primary care providers.

In these countries, there is a move towards competency-based assessment and the opportunity for student midwives to have their own (supervised) caseload of women for whom they provide continuity of care in the final year of study. However, there are still minimum practice requirements in programs, including the need for students to attend at least forty births, in order to reach competency. By comparison, the maximum number of births that Australian midwifery students are required to participate in is twenty. Brodie and Barclay (2001: 106) point out that all current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries. They point out that in the UK Canada and NZ, regulatory boards use agreed national criteria to accredit, not only curricula, but also teachers, facilities and services. In these countries regulatory frameworks ensure that theory and practice are integrated in equal proportions in programs and that adequate staff to student ratios are maintained in clinical areas.

Australian midwifery education for qualified nurses

With two exceptions[2], all midwifery education programs for nurses who wish to enter midwifery are at postgraduate level, either in the form of a Graduate Diploma, or, in three cases, as a Masters degree. This is in keeping with other postgraduate programs for nurses since midwifery is presumed to be a specialist area of nursing in regulation (Brodie & Barclay 2001). The AMAP Education Survey (AMAP 2002) revealed that courses for nurses undertaking full time midwifery education in Australia varied in length from two academic semesters of approximately fourteen weeks each, to one calendar year. However, financial pressures meant that almost two-thirds of students undertook midwifery education part time, and continued to work as nurses throughout this process. Courses varied considerably in terms of the amounts and ratios of midwifery theory and practice hours[3] and high attrition rates on graduation were reported. One year 'Graduate Midwifery Programs' in some states and territories provide extra education and address the fact that graduates do not emerge from programs as confident, competent practitioners.

In midwifery circles there has been increasing unease about the fact that Australian nurses who wish to become midwives meet lower standards and undertake a significantly shorter midwifery education program than nurses in other western countries. The notion of midwives graduating from specialist nursing courses (some at Masters level) as 'beginning level midwifery practitioners' (Glover 1999) is at odds with the international view that midwives should graduate capable of 'hanging up their shingle' from day one of qualification. Furthermore, since Australian midwifery education programs for nurses are so much shorter than those of other countries, involving little, if any, community experience (AMAP 2002), Australian midwives currently have to undertake further education if they wish to register to practise as midwives overseas.

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[2] Two South Australian universities offer midwifery education for nurses through a one year Bachelor of Midwifery.

[3] The AMAP Educational Survey reported that, according to midwifery course coordinators, the theory component of courses ranged from 174 – 400 hours in the majority of courses (up to 2,160 theory in external courses). Midwifery practice hours ranged from 500 – 1824 with the majority being less than 1000 hours.

The introduction of the Australian Three Year Bachelor of Midwifery

Increasingly in Australia, the case has been made for a three year Bachelor of Midwifery (Hancock 1992, ACMI Victoria 1999, Leap 1999, Owen 2000, ACMI 2002). The rationale for the introduction of an Australian Bachelor of Midwifery (BMid) has been explored by the Australian College of Midwives Incorporated (ACMI) in terms of the College's overall aim to increase the number of competent midwives and midwifery graduates in all areas of Australia. According to the ACMI, 'the bottom line for any developments has to be improvements to the services offered to childbearing women, their families and communities' (*ACMI BMid Information Pack*).

In 2002, over 150 students commenced study in a three-year BMid in four universities in South Australia and Victoria. As in other countries, competition for places in these courses was extremely keen. At least four other universities in New South Wales, ACT and Victoria are planning to start a three-year BMid in 2003.

The ACMI has played a major role in the development of the three year BMid through coordinating the ACMI BMid Taskforce. This group, representing midwifery educators from each state and territory, has developed national standards for the accreditation of three-year BMid programs and hopes to work collaboratively with the registering authorities in the future regarding the implementation and evaluation of these standards. An advisory panel of international midwifery education experts was identified, all of whom have offered support for the introduction of a BMid in Australia. They have shared their countries' experiences of developing similar programs and will have an ongoing role in reviewing the ACMI Standards for the Accreditation of three year Bachelor of Midwifery Courses (ACMI 2002) and related standards and curriculum documents. The ACMI BMid Taskforce has a commitment to ensuring international compatibility so that graduates of the Australian BMid courses will be able to register to practise in other countries without having to undergo further training and education.

The Australian Double Degree in Nursing and Midwifery

In 2002 in one Australian university a double degree in Nursing and Midwifery was commenced. This double degree program integrates both nursing and midwifery throughout a four year program. At least one other university is planning a four year double degree with a different format - three years of nursing followed by one year of specialisation in midwifery. Supporters of this plan argue that, in effect, this reflects the current situation in Australia where graduates of three year nursing degree programs are able to enter a one year post-graduate diploma in midwifery, often without having had to practise as a nurse first. The only difference, they claim, is that graduates will qualify in midwifery at Bachelor level. In personal communications with two midwifery educators who do not wish to be named, the following arguments supporting the double degree (as opposed to the three year BMid) have been put forward:

- The workforce crisis, particularly difficulties in recruitment in both midwifery and nursing, is addressed by a double degree since the course is very popular, particularly with school leavers.
- Any strategy that enables the current quota of midwifery student places to be filled in a situation where courses are threatened with closure due to low enrolments must be tried in those Schools of Nursing who have decided not to support the three year BMid.
- Nursing's authority in university Schools of Nursing and at Nurses Board level will enable successful course approval and implementation of the double degree which is seen as more politically acceptable to nursing leaders (who see midwifery as a specialisation of nursing) than the three year BMid.
- Australia has different needs from other countries in that rural and remote communities need dual educated nurse-midwives.
- The standards being proposed by the ACMI for the three year Bachelor of Midwifery are unrealistic and cannot be met in Australia, whereas the double degree will meet existing accreditation standards.

Discussion

The arguments presented here in support of the double degree are justifiable in terms of maintaining the status quo of Australian midwifery as a specialisation of nursing. A one year midwifery program, either following a nursing degree program or integrated within a double degree will perpetuate a situation where Australian midwifery graduates are being prepared to meet different standards from midwifery graduates in all other comparable western countries.

Rather than viewing midwifery as a specialisation of nursing, the ACMI articulates midwifery as a discipline in its own right with a discreet, well defined sphere of practice; the professional body for Australian midwifery therefore does not support the existing or proposed double degrees in nursing and midwifery (correspondence with ACMI Executive Officer, 2002). The ACMI has concerns that midwifery students are in danger of being locked into courses that are internationally

incompatible, that do not allow enough concentrated time for students to gain the experience they need to become practitioners in their own right, able to cross the interface between hospital and community settings in the new models of care proposed in government documents and demanded by consumers. There are also concerns that students will not develop enough theoretical understanding of midwifery, even where double degrees may allow midwifery to eat into more than a year's worth of a three year nursing degree within a four year program. It may be worth considering that double degrees in other subjects, for example Accountancy and Law, prepare students over five years in order for them to gain appropriate knowledge in two professions. In not recognising nursing and midwifery as separate disciplines, Australian midwifery may be at risk of short-changing students and ultimately the services offered to the public by both professions.

It is accepted throughout the world that when a nurse graduates from a three year degree program, s/he has to undertake further education, whether formal or informal, in order to specialise in an area of nursing. This is not the case for midwifery, which licenses midwives to practise from day one of graduation according to the full sphere of practice described in the *International Definition of a Midwife* (ICM 1992). Questions must be asked as to how graduates of four year double degree programs are going to be able to practise in rural and remote areas as nurses and midwives without considerable further education in both disciplines, particularly in areas where access to tertiary care is limited and practitioner skills are required. Midwives educated through three year BMid courses who wish to work in any job that requires a dual role in both midwifery and nursing will be competent to fulfill the midwifery (practitioner) aspect of the role, but will expect to undertake further education in nursing. In some cases this will mean a Bachelor of Nursing. This is not unreasonable if quality services are to be maintained in rural and remote areas. However, midwifery models of care are not urban phenomena and Australia is not unique in its geographical proportions. In many rural and remote areas, both in Australia and elsewhere, examples are emerging of the re-organisation of maternity services in ways that do not require midwives to work as nurses. This can have far reaching consequences for women as demonstrated in the far northern reaches of Canada, where remarkable improvements in outcomes for Indigenous mothers and babies have been achieved through collaborative midwifery projects (Tyson 2001).

The standards proposed by the ACMI for the three year BMid are standards that should inspire confidence in midwifery graduates. There is a strong argument that any midwifery education program should meet these standards. Some would argue though that Australian maternity services should not be compared to other countries; that Australian women do not necessarily want continuity of care from midwives; that they prefer to get this service from private obstetricians or from their general practitioner. Research carried out by Zadoroznyj (2000) and Homer et al (2000) refutes this notion in demonstrating that many women do not ask for midwifery care because they have no way of understanding the concept until they experience it since information about midwifery-led care is not widely available. Once exposed to midwifery care, women in these studies were extremely positive about midwifery care and the majority indicated that this is what they would choose in subsequent pregnancies. It is worth bearing in mind that in NZ, where ten years ago government funding enabled women to choose a primary caregiver, the majority – over 75% - of women now choose midwives.

In other comparable western countries, midwifery is being promoted as a public health strategy to address health inequalities (RCM 2000a, 2000b, Garrod 2002). Currently, the potential for students in Australian midwifery courses to gain experience in this role is limited with eleven courses not providing students with placements in any areas other than hospital wards (AMAP 2002). The AMAP Education Survey identified that 'community placements' in some other courses included 'a reproductive medicine unit', 'medical practitioner's rooms', 'a birth centre' or 'an elective in a rural hospital'. Clearly, any placement other than a hospital ward is being defined as 'community' making it hard for students to gain any understanding of primary health care principles in action. Instead, Australian midwives are being educated for an acute care role in the majority of courses and are not exposed to experiences that might foster an understanding of their potential role as primary care providers based in the community and the difference of this role from that adopted as a midwife (or nurse) in a hospital team.

The fact that the indemnity insurance crisis is currently limiting midwifery students' practice placements to hospital settings is a further cause for concern. If students are unable to follow women through their experience of childbirth by visiting them in their homes, particularly in the early weeks after birth, the standards set by the ACMI and certain regulatory authorities will not be reached; students will be educated for a limited role in hospital practice that does not include providing continuity of care to women. Furthermore, the increasing use of technology in childbirth and escalating caesarean section rates limit the opportunity for students to learn about normal childbirth (Davies 1996, Hunt 2000). These

concerns have been explored by Barnes (1997), who describes Australian midwifery students struggling to develop a 'woman centred' approach to care in the light of the increasing medicalisation of childbirth, in particular, rising epidural and Caesarian section rates.

Recruitment to DEM education programs in other countries has continued to be highly competitive, attracting both mature age students and school leavers. It is likely that the same will be true for both the Australian BMid and the double degrees in nursing and midwifery. As with the current one year programs for nurses, as long as there are no national standards for midwifery education, graduates emerging from programs will vary considerably in terms of the levels of competence and experience they have been required to meet by state and territory nurses boards. If Australia is to continue to have widely disparate models of midwifery education, decisions have to be made as to whether programs should meet the same standards or whether the present system, where some midwives graduate having had drastically reduced midwifery practice opportunities, is acceptable.

Conclusion

As demonstrated in this paper, many questions need to be answered in terms of the standard and type of services midwives will be able to offer to Australian women in the future. It will remain to be seen whether graduates of the new programs will be confident, competent practitioners; whether graduates from double degrees will choose to work primarily in nursing or in midwifery; or whether graduates from any programs will choose to work in dual roles. What is required urgently is Commonwealth funding to evaluate all models of midwifery education and to investigate whether the current standards are appropriate to enable Australian midwives to provide safe, collaborative care within the proposed new models of maternity service provision that place women at the centre of care. It is timely for the regulatory authorities to liaise with the ACMI so that the professional organisation representing midwives is centrally involved in setting and maintaining national standards for midwifery education and practice.

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Chapter 5

Rhetoric to Reality: Engaging Midwives in Practice Change

The primary purpose of a professional doctorate is to enable changes to practice through the development and extension of knowledge (Faculty of Nursing Midwifery and Health, 1999). The last chapter in this thesis addresses various ways in which I have aimed to use rhetorical innovation to engage midwives in the process of making change happen. Texts have been designed to make sense to practitioners at a personal, practice and professional development level. Examples of initiatives that employ rhetorical innovation to attempt to meet these ends, mirror the title of this thesis in their strategic intent to 'narrow the gap between rhetoric and reality' in Australian midwifery.

In order to engage midwives who do not necessarily read journal articles or engage in academic study, I am committed to writing for publications that have a 'magazine style' on a regular basis. The first two portfolio texts are examples of this effort. They were published in the newsletter of the New South Wales (NSW) branch of the Australian College of Midwives, the NSW Midwives Association (NSWMA). Designed to be 'eye-catching in the tea room', the glossy format of *Midwifery Matters* is peppered with illustrations which act as symbols to communicate meaning.

The first portfolio piece was crafted in response to requests from rural midwives to the NSWMA for guidance about which books it would be useful to buy for their workplace libraries. The choices were carefully planned with the particular needs of these midwives in mind:

> ***Portfolio Text 12a:***
> 'Resources Matter: Top Ten Resources for Practising Midwives: Nicky Leap's Choice'
> *Midwifery Matters.*

The notion of 'woman centred care' may seem somewhat amorphous to many midwives in terms of what the concept means in their day-to-day working lives. The next portfolio text is an example of applying woman centred care in specific practical acts that enable situations where women may feel more powerful. It provides a rationale for the midwife stepping back so that the woman can pick up her newborn baby. This is argued with a photograph, carefully chosen to engage attention.

Portfolio Text 12b:

'To Have and to Hold' *Midwifery Matters*. 2003.

A set of portfolio texts that aim to raise awareness of how the language we use as midwives both reflects and constructs the culture in which we practise, are analysed. Three components of a conference presentation were created with an aim to startle midwives into thinking about language. These were designed in collaboration with my co-presenter, Caroline Homer. A PowerPoint presentation introduced the exploration of woman friendly language. This was followed by an invitation to engage in a crossword puzzle competition - 'Words to Reconsider in Midwifery Practice'. The clues to the crossword were reinforced by the enactment of a short skit including all the 'words to reconsider'. Midwives were invited to compete for a prize in pairs or groups of their choice – 'first correct answer to be drawn out of a hat on the following day'.

Portfolio Text 13a:

'Acting on our language'. Conference presentation. NSWMA Annual State Conference Proceedings. 2003.

Portfolio Text 13b:

'Words to reconsider' skit script

Portfolio Text 13c:

'Words to reconsider' Crossword Puzzle, Clues and Completed Puzzle. *NSWMA Annual State Conference Proceedings*. 2003.

The final portfolio text is a transcript of a keynote address that I gave to a midwifery conference in Melbourne. I was asked to speak about how midwives can keep birth normal in a medicalised environment. I have chosen to analyse this paper here because it focuses on engaging midwives in the rhetorical innovation associated with the three major practice development areas of my work: midwifery continuity of care; antenatal and postnatal groups; and the art of being with women in pain in labour. Practice change in these areas is argued in terms of the midwifery rhetorical concept of 'keeping birth normal'.

Portfolio Text 14:

How Can Midwifery Practice Flourish in a Medicalised Environment? Keynote address presented at a conference organised by Southern Health and Deakin University, Victoria: 'Midwives Can Make a Difference', held at Monash Medical Centre, 4 December 2002.

Portfolio Text 12a

‘Resources Matter: Top Ten Resources for Practising Midwives: Nicky Leap’s Choice’ *Midwifery Matters*.

Portfolio Text 12b

'To Have and to Hold' *Midwifery Matters*. 2003.

Portfolio Text 13a

‘Acting on our language’. PowerPoint presentation.

Portfolio Text 13b

‘Words to reconsider’ skit script

Portfolio Text 13c

'Words to reconsider' Crossword Puzzle, Clues and Completed Puzzle.

Trilogy of presentations and crossword competition presented at *NSWMA Annual State Conference* 2003.

Portfolio Text 14

'How Can Midwifery Practice Flourish in a Medicalised Environment?

Keynote address presented at a conference organised by Southern Health and Deakin University, Victoria: 'Midwives Can Make a Difference', held at Monash Medical Centre, 4 December 2002.

Acting on our language

The language that we use in midwifery practice often reflects the culture in which we practise – a system 'designed for the army and adapted for nurses' (Flint 1988: 25). Words and phrases also have the power to both construct and perpetuate a culture in which women feel trivialised, jolly-ed along, patronised and disempowered (Leap, 1992). Messages are often received at a conscious or subconscious level that do not sit easily with our intention to provide 'woman centred care' and enable women to feel more powerful and in control of their lives.

Deciding which words we will try not to use is not straightforward. It is difficult to stop using words and phrases that are entrenched in everyday midwifery practice, in women's notes and in the terminology that surrounds us in conversation, documentation and signage. There are also the challenges to our assumptions to consider. These assumptions are inevitably embedded in our personal life experiences, our values and our attitudes. For example, well meaning terms of endearment that make one woman feel cherished may make another woman shrink away from us as she grapples with what she sees as inappropriate or patronising familiarity.

Increasing our individual awareness about the potential impact of the words we use starts with an exploration of who has the power in any given situation and how this is manifest in language and communication (Leap 1992). This is therefore a deeply political process that challenges us to consider inequalities, particularly those associated with sexism, racism, class and homophobia.

In order to raise consciousness about such issues, midwifery students at UTS complete an assignment that is a 'written role play' – a scenario where a midwife interacts with a woman who has asked for information about a particular topic. The students have the opportunity to think about every word that is used as the midwife listens to the woman and responds to her query in a way that shares knowledge and power and avoids an authoritarian approach. We have drawn on our experiences of this assignment as a group of learners and two lecturers in presenting some scenarios that may not have been that useful or empowering for pregnant women at 'St Elsewhere Hospital'. In order to promote a methodical, in-depth consideration of words and phrases, we have incorporated some of these words for re-consideration in a crossword – with a prize for the first correct entry pulled out of a hat.

We do not expect everyone to agree that each of the answers to the clues in the crossword is potentially harmful to women's experience of pregnancy, birth and new motherhood. However, we wish you a merry and thoughtful time as you ponder and quibble over the crossword in pairs, in

groups – or if you prefer, in solitary 'confinement'. Now there's a word we can probably ALL agree to avoid for starters!

Crossword designed by Nicky Leap with editing help from Caroline Homer and James Scandol who made the clues less obscure and Avon Strahle who worked magic on the internet crossword program. Please feel free to reproduce the crossword with due acknowledgement.

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Discussion:

Engaging Midwives in Practice Change

'As one midwife to another…'

In different ways, each of the portfolio texts in this chapter was designed to engage midwives in rhetorical discourse that facilitates practice change. The style of each text therefore speaks directly as 'one midwife to another', acknowledging the daily 'realities' (challenges) of practice and suggesting a range of strategies to narrow the gap between 'rhetoric and reality'. The tone of each assumes a shared passion for midwifery, even though common sense would suggest that this is clearly not going to be the case in many instances. These texts employ, full throttle, the three main components of rhetorical persuasion suggested by Aristotle:

Logos — the appeal to reason
Pathos — the appeal to emotions
Ethos — the appeal of the rhetor's character or personality

Whereas all the portfolio texts in this thesis appeal to the reason (*logos*) of the audience, the nature and circumstances of texts that I have designed to motivate and engage practising midwives allow for an emotionality (*pathos*) that is, to a greater or lesser degree, depending on the audience and context, restricted, in other, more formal arenas, such as policy development or academic writing. I am aware that my enthusiasm and passion for midwifery is apparent in these texts and that, although it is not consciously harnessed for effect, this can act as a motivating force for practice change. An awareness of the effect of self on others and the need to find ways of being in the world that address ethical issues such as social justice, were important components of feminist consciousness raising groups in the 1970s and 1980s (Bell & Klein, 1997; hooks, 2000). In classical rhetoric this concept was called *ethos*. The notion of locating the ethical in the character or personality of the rhetor was justified in terms of recognition that, in spite of efforts to build arguments that cannot be refuted, uncertainty always prevails (Corbett & Connors, 1999). In contemporary midwifery discourse, the reputation of the rhetor probably affects the readiness of an audience to engage with the ideas and set of symbols offered as a means of persuasion. However, Aristotle made it clear that it was the speech itself that needed to convince an audience that the speaker was a person of sound sense, high moral character and benevolence.

The texts all engage the reader or listener through the use of personal pronouns. I could pretend that this is a deliberate strategy to flatten hierarchical ways of communicating and to promote solidarity (Bell & Klein, 1997). However, the fact is that this style of engagement, with its roots in

the Women's Liberation movement of the 1960s and 1970s, has become a sub-conscious characteristic of the way in which I communicate with other midwives – a phenomenon that has become obvious to me through engaging with the rhetorical analysis of this thesis.

Lynne Pearce (2004) suggests that the most visible and discussed innovations in contemporary feminist thought have centred around the use of the personal pronoun. She explores how the accepted imperative to situate the self in theoretical writing has been exceeded by the need to analyse the power wielded by the use (or not) of the 'I's and 'we's' in multiple forms of written and spoken discourse, in particular in the art of polemic. The use of 'we' in the portfolio texts in this chapter assumes a degree of commonality and a blurring of the boundaries between audience and rhetor that mirrors the shifting interface of epistemology and polemic in the interest of 'the Cause' described in Chapter Two. 'We' is used to denote that, as midwives, we are a community of participants who have developed language that both explains and constrains our understandings and values. While this is a rhetorical strategy to build and count on a sense of solidarity to promote action, it is clearly problematic whenever one person assumes an identity with a primary audience. The 'I' cannot assume who 'we' is without denying the diversity of individual meanings that will be triggered by the rhetorical innovations being offered. Moreover, Morwenna Griffiths reminds us that feminists have worked hard at identifying how male academic discourse uses 'we' in a way that slips from inclusion to exclusion with respect to women; she cautions us to think of 'we' as a 'slippery word' (Griffiths, 1995 p.16).

In the portfolio texts, the shifting of 'we' to 'I' and back occurs self consciously whenever a story or recommendation is made that arises from my own experience. The 'we' that sits happily within the community of midwives and the world of practice is often removed from the situation ('reality') that needs to change and becomes 'I' within a rhetorical innovation that claims authoritative knowledge as a suggested strategy. Pearce (2004 p.15) draws on a range of texts to identify how any written or spoken word is '*double*-voiced' in as much as the narrator's attention is directed towards both the listener and the 'object of utterance'. The portfolio texts in this chapter could be seen as '*triple*-voiced' in that the rhetorical innovations also have an overt focus on strategies to change the object of utterance. Within this tripartite, the fluid use of 'I' and 'we' is used to capitalise on the 'ethos' of my leadership role, and the authority to comment that is invested in me by the audience, while attempting to forge a sense of common identity and purpose.

Accessible rhetoric: writing for the 'popular midwifery press'

The first two portfolio texts relate directly to practice development and are written in conversational style with attention to eye-catching graphics. Each text aims to stimulate interest and

discussion amongst midwives who may not engage in tertiary education or structured professional development. The audience is specific in that the *Midwifery Matters* magazine is circulated to members of the New South Wales (NSW) branch of the Australian College of Midwives, the NSW Midwives Association (NSWMA). However, anecdotal reports suggest that the 'magazine' style of the newsletter attracts readers beyond college membership and that copies are shared in the workplace at midwives' desks and in the 'tea room'.

In discussing the fear and anxiety that exists in society regarding feminism, bel hooks (2000) suggests the need for a proliferation of easy to read texts that identify how feminism has touched all our lives in a positive way. The purpose is to 'let the movement into everyone's heart mind and heart (hooks, 2000 p.x), the Aristotelian concept of combining 'logos' and 'pathos' in order to persuade. The same principles are at work in the first two portfolio texts, which aim to engage the reader through innovative ways of sharing ideas and information.

The rhetoric of 'sharing'

The first text is responsive to requests from rural midwives to the Education and Research Sub-Committee of NSWMA, for recommendations regarding resources to enable contemporary practice and professional development. The article begins by sharing the committee's discussion regarding the drawbacks of sending out a list of resources 'that soon become out of date in a culture of prolific publications'. The 'Desert Island Discs' idea is presented as a group innovation although there is an apologetic hint that 'the ex-Pom' (me) initiated the idea. The tone of the article is enthusiastic and conversational with recommendations peppered with personalised stories – 'I put my copy (of the MIDIRS Digest) in the loo and read a page or two every day' – aimed at attracting interest. An implied acknowledgement of expertise is articulated in a levelling exercise that invites readers to contribute their own suggestions for a 'Top Ten' list, with an incentive in the form of a book prize.

Within the article, the feminist rhetoric of 'sharing our ideas and knowledge', explored earlier in this thesis, is a major theme. Finding easy ways to engage in discussing 'evidence based practice' with each other and with women is assumed as an essential component of practice. The idea of looking up evidence with women - 'Let's see what the research says' - implies that the reader would (or should) also employ this way of engaging with women as everyday practice. Vaginal birth after Caesarean section is the example deliberately chosen, without any overt suggestion that the idea might be challenging to some midwives in terms of the power dynamics of the midwife-woman relationship around expertise and decision making (Kirkham, 1996). Lesley Page (1999) employed a similarly attention seeking example – the story of a woman wanting to have her seventh baby at

home - to explain how woman centred practice and evidence based practice merge in the 'Five Steps to Evidence Based Practice'. This example is highlighted in the portfolio text in order to draw on the curiosity of the reader, enticing them to access the resource and explore its potential contribution to their thinking and practice.

The poetics of everyday midwifery practice

The other *Midwifery Matters* text invites midwives to re-think familiar, everyday practice in the interest of woman centred care and promoting understanding of the power dynamics around the moment of birth. The case is made for the midwife to step back and not get in the way of the woman's intensely personal experience of shifting from the intensity of her embodied experience of giving birth, to focusing externally and engaging with her baby (Allen, 1996). Again, there is the sharing of 'thought provoking' ideas but the rhetor (me) calls on a sense of collective wisdom in stating, 'We have all seen…'

The poetics employed to support the argument:

> …the moment of birth belongs to the woman, can have profound significance; …step back, wait and watch in awe; … neurohormonal cascades release their magic and women withdraw into their body-besieged worlds; …a primeval process of curiosity; … an act of profound acceptance and love… (Portfolio text X)

This language is in direct contrast to the tone of descriptions of the 'reality' of most births:

> … handing the woman the baby as if we were presenting her with a present; … reclining women recoil when the attendant scoops the baby up and ceremoniously places her/him on their abdomen (often announcing the baby's gender with a triumphant flourish) (Portfolio text X).

A string of rhetorical questions pre-fixed by, 'We ask ourselves…' allow no room for the rhetor to be isolated from the audience. They are compelled to be part of the reflections as they are swept along by the insistent text.

A story is told to illuminate the arguments being presented. Again, an extreme example from my own experience of practice is chosen to demand attention. This process of sharing stories in order to render midwifery practice coherent invites the listener or reader to look for resonance within their own values and experiences:

> A story tells more than its tale. It speaks of context and of values. Listeners absorb the story through a web of their own view of the world and by links with their own stories… Stories reveal important aspects of midwives work and their careful examination may open up new dimensions in which we can usefully be with women (Kirkham, 1997 p.183).

Kim Walker (1995b) suggests that the value of story telling arises from the opportunities to articulate, but then critique, the complexity and diversity of clinical practice. He proposes a two way

process where 'our lives and experiences are not merely reflected in stories: they are instead, actually created by and through them' (Walker, 1995b p.156). As Hannah Williams (2003) identified when observing and interviewing midwives in a London birth centre, almost all narratives began with, 'I had a lady who…' Williams suggests that this is the midwifery equivalent of 'Once upon a time….'. She concluded that midwifery stories play a major role in developing an occupational culture in which the physiology of birth is admired and respected, where women's strength in giving birth is acknowledged and where midwives are encouraged to develop new skills. In this text, my own version of 'Once upon a time' begins, 'I often tell the tale of attending…' and suggests both an appreciation of the learning inherent in individual experiences of 'being with' women who are giving birth, as well as the value of sharing these stories

The language of midwifery practice

> Giving birth. But who gives it? And to whom is it given? … And *delivering*…who delivers what? How can you be both sender and receiver at once? Was someone in bondage? Is someone made free? Thus language muttering, in its archaic tongues of something, yet one more thing, that needs to be renamed (Atwood, 1984 p.2).

My experience of being a member of the Association of Radical Midwives in the UK had a profound effect on my understanding of how the language we use both reflects and constructs the culture in which we practise midwifery. As feminists, we developed a way of being in the world that assumed we could create that world as well as discover it through language (Griffiths, 1995). The trilogy of portfolio texts on language aim to introduce this concept, in a lively and easy-to-understand way, through the use of a crossword puzzle and a 'skit' to enhance the clues. Each builds on my original article, 'The Power of Words. Confining Women with words: how language affects midwives' practice' (Leap, 1992), which is presented in Appendix C. The article is still used widely in midwifery curriculum documents in Western countries (personal communications with midwifery educators). Its long-term appeal appears to be based in the simplicity of the way in which it introduces complex issues and the fact that it triggers learning opportunities that counteract the 'official' language of midwifery education, namely the language of obstetrics with its emphasis on measuring and setting norms (Kirkham, 1986, 1993, 1997).

The set of portfolio texts concerning language provide an innovative vehicle for enabling discussion about how language reflects, reinforces and potentially can challenge, power dynamics. The next step is for midwives to engage in an ongoing process of analysing how the unfolding of this awareness is played out in practice, in particular how we avoid the tendency to be trapped in dichotomous thinking.

In identifying the difference between woman friendly language and the language of obstetrics, we are at risk of creating a new set of dynamics that mirror those that potentially disempower women. Fielder, Kirkham, Baker and Sherridan (2004) have explored how the language of midwifery has a tendency to both force and reflect dichotomous thinking. They suggest that midwives have learned to think in binary opposites and that there is merit in addressing dualism in language use and the effect it has on both thinking and practice. The authors explore the types of opposites used by midwives and identify how this way of thinking has been learned from society, medicine and the culture of midwifery itself:

> Midwifery thinking and writing is full of opposites: normality-abnormality, safe-unsafe, health-illness, life-death, safety-danger (or in more contemporary jargon, risk), pathology-salutology, professional-lay, autonomy-dependency. There are also dichotomous, although less literally opposite pairs of concepts, such as breast-bottle, home-hospital, physiology-pharmacology, midwifery model-medical model, and midwife-obstetric nurse (Fielder et al., 2004 p.6).

Fielder et al (2004) suggest that our expressions of opposites often imply value judgements that separate off what is unacceptable within social, medical and midwifery norms. If one side of an opposite is seen as 'good' there is the potential to demonise the other side as 'bad'. This polarisation can become a habit, manifesting in bullying behaviour and underpinning much of the horizontal violence that is endemic in midwifery practice (Leap, 1997b).

Dichotomous thinking also has the potential to force people and ideas into rigid standpoints that reduce richness and complexity (Sherwin, 1989). According to Fielder et al (2004 p.7), the challenge is to make sure that dualistic thinking does not hamper our acknowledgement of different stages in colleagues' careers or thinking; that we continue to explore all the 'invisible between the extremes'; and that we analyse and resist how binary thinking affects midwifery practice. This includes engaging with women around the complexities of uncertainty and questioning how our hierarchical rhetorical positioning of 'normal' affects women whose experiences fall outside of such constructs.

The notion of binary opposites was initially developed by Jacques Derrida (Caputo, 1997) who identified that language cannot escape the built-in biases of the cultural history that produced it. Hidden mechanisms are always at work subtly influencing meaning in language. Identifying these underlying assumptions can be the first step in demonstrating the concealed power of symbols to shape thinking. According to Derrida (Caputo, 1997), no one escapes these elusive qualities of language and writers are caught up in subconscious networks of meaning that affect how we communicate ideas and experiences. Thus, even a skilled rhetor creates texts that resist her conscious control. An understanding of this notion has challenged traditional concepts of how rhetors manage persuasion. The goal has to be to remain acutely sensitive to the conscious and

subconscious historical, social and linguistic 'constructedness' of our beliefs and practices (Herrick, 2001 p.52). This requires an ongoing process of social negotiation within which meanings are ever shifting.

The midwifery art of keeping birth normal: rhetorical innovations

The final portfolio text in this chapter weaves together major areas of my work in practice development under the umbrella of a favourite midwifery rhetorical concept: 'The Midwifery Art of Keeping Birth Normal'. The context was a keynote address at a midwifery conference in Victoria, optimistically entitled, 'Midwives Can Make a Difference'. Since I was asked to identify how midwives can do this in a medicalised environment, I chose a rhetorical innovation aimed at situating strategies within a familiar context that could be readily grasped. The telling of a fictitional, everyday story – 'The birth of Jason Smith at St Elsewhere Hospital' – was deliberately constructed to assist midwives in the audience to identify the issues within the familiar culture of a 'labour ward'. The story describes well-meaning midwives and doctors struggling to provide a safe, kind service under conditions hampered by staff shortages, fragmented care, public expectations, medical dominance and all the other components of the stresses associated with maternity service provision in large tertiary maternity units. The scenario is then re-constructed – 'the clock is turned back' – in order to suggest how the story might have been different, had another set of circumstances prevailed at each stage of the journey to Jason's birth for his parents, Mary and Wayne Smith. The arguments portrayed in the re-telling of the story make the case for a range of changes to practice, some of which are within the grasp of the practitioner, others that would require significant changes to systems.

Narrowing the gap between evidence and practice

In contemporary Western midwifery culture, the credibility of midwifery rhetoric lies in its attempts to narrow the gap between evidence and practice in a way that resonates with both practitioners and childbearing women (Sandall, 1998). Since this was a keynote address and there were no conference proceedings, I was not compelled to provide the evidence to support my arguments that things might have been different for Mary Smith, had she been offered a particular model of midwifery continuity of care. I was able to engage in a process of insinuation that the changes to the story would automatically make a difference to her experience of giving birth. However, throughout the talk there is reference to research to back up the arguments used, introduced by phrases such as 'We know that…', in order to project confidence in both mine and the audience's own knowledge and understanding of research that informs practice. An analysis of the rhetorical

innovation in this paper demands justification of the arguments used, through identification of the literature that underpins the validity of these claims.

The keynote address is used as an opportunity to disseminate my own research findings about midwifery perspectives on being with women in pain in labour. Quotations from midwives are read out to make the case for an approach that claims to be the key to keeping birth normal. The appeal to avoid 'offering pain relief' routinely is directed at individual midwives. It is offered as a strategy to keep birth normal that is within their grasp, one that does not necessarily require systems change. However, there is recognition that any individual who adopts a different approach is working against the culture of offering pain relief in the name of choice and kindness, a style of care that is pervasive in hospital birthing units. The rhetor (me) aims to create a sense that she understands the difficulties faced in everyday practice in order to create a sense of solidarity and the credibility that will render the audience open to considering the suggested changes.

Evidence based messages are presented in a way that assumes the audience know the evidence that women's satisfaction with their experience of birth is not related to analgesia (Hodnett, 2002; Morgan, Bulpitt, Clifton, & Lewis, 1982) and that the most powerful influence on a woman's feeling of satisfaction is the attitudes of her caregivers (Hodnett, 2002). The potential for epidurals to increase the risk of instrumental birth (Elzschig, Lieberman, & Camman, 2003); the fact that there are good reasons to avoid giving labouring women pethidine (Heelbeck, 1999; Olofsson, Ekblom, & Ekman-Ordeberg, 1996); and the potential for women to feel empowered through their experience of labour pain (Niven & Murphy-Black, 2000) are also issues reinforced through the story of Mary Smith.

The evidence for many of the other strategies suggested in the portfolio text has been explored by Jane Sandall (2004) in her review of research findings related to promoting normal birth. This includes factors related to Mary Smith's story such as:

- Providing continuous physical, emotional and psychological support during labour
- Midwifery care for women with no serious risk factors
- Freedom of movement and choice for positions during labour and birth
- Avoiding continuous fetal monitoring when mother and baby are well
- Effective multidisciplinary teams and shared decision making.

The re-play of Mary Smith's story throws out to the audience the oft-quoted challenge suggested by Jo Green and colleagues (1998) and Gay Lea (1997) that women place more value on having a competent, caring midwife looking after them in labour, than on having a midwife that they know.

This notion is posed as a rhetorical question around the story of Mary Smith. Subsequently, the evidence and researchers' conclusions for this assumption are critiqued; the case is made for Australian women choosing midwifery continuity of care once they are aware of the possibility (Zadoroznyj, 1996, 2000) as well as the increased satisfaction women experience where they have a known caregiver in labour (Homer, Davis, & Cooke, 2002; Walsh, 1999).

Sandall identifies the difficulties in drawing conclusions from randomised controlled trials (RCTs) studying continuity of care, due to ambiguous definitions of what is meant by continuity of care and the range of different models studied. Randomised controlled trials do not demonstrate detectable differences in operative birth, induction, augmentation, and breastfeeding rates; neither were differences demonstrated in overall Apgar scores, low birth rates, still births, or neonatal deaths. However, trials have shown that women are more likely to attend antenatal classes and be pleased with their care. Moreover, continuity of care was shown to reduce antenatal hospital admissions; the use of drugs for pain relief and the need for neonatal resuscitation (Hodnett, 2004a).

Although there is no strong evidence to conclude that continuity of care in team midwifery projects improves normal birth rates, non-randomised studies suggest that the type of care suggested for Mary Smith (caseload practice) has been shown to make a difference in terms of 'keeping birth normal' (Benjamin, Walsh, & Taub, 2001; Page, Beake, Vail, & McCourt, 2001; Sandall, Davies, & Warwick, 2001). The model of care described in the re-play of Mary Smith's experience is the one I used to work in. Originally the South East London Midwifery Practice (Leap, 1997c), it became the Albany Midwifery Group Practice in 1997 and is held up as an example of community based midwifery that makes a difference (Reed, 2002a, 2002b). An evaluation of the Albany Midwifery Practice made comparisons with other midwifery group practices at Kings and identified that 'the Albany practice was very successful at facilitating normality in pregnancy and birth' (Sandall et al., 2001). Significant differences in outcomes were reported in terms of increased satisfaction; normal vaginal birth; home birth; and breastfeeding rates and reduced rates of induction; Caesarean section; use of pharmacological pain relief; and perineal trauma (Sandall et al., 2001).

During the period of my doctoral study, I was involved in the development of an Australian model that aimed to replicate the Albany model. The Northern Women's Community Midwifery Project (NWCMP), identified in the keynote address, has similar features, in that the midwives:
are community based in a publicly funded model

- cover a geographical area of extreme socio-economic deprivation
- offer booking visits and a 36 week visit in the woman's home
- run antenatal and postnatal groups

- offer home birth as an option

Preliminary evaluations of the NWCMP (Nixon, Byrne, & Church, 2003) suggest similar positive outcomes for women and midwives as those identified in the evaluation of the Albany Midwifery Practice (Sandall et al., 2001). It is possible that the success of the Albany Midwives and the NWCMP lies in the fact that they provide a social model of midwifery care, one that sees bringing women together in groups as a crucial strategy to develop a forum where they can learn from each other and develop friendships and support networks (Leap, 1991). As suggested by Mavis Kirkham, 'linking women with others makes them stronger' (Kirkham, 1986 p.47). Where the focus of antenatal groups centres on antenatal care as well as education and support, significant improvements in outcomes have been identified in disadvantaged communities in the USA (Ickovics et al., 2003; Schindler Rising, 1998).

The role of midwives in promoting psychosocial well being was identified by Anne Oakley and colleagues (Oakley, Hickey, L, & Grant, 1996; Oakley, L, & Grant, 1990) who demonstrated, through a randomised controlled trial, that the effect of midwives making themselves available, in a 'listening ear' capacity, had profound long term consequences on the relationships and social lives of women, their children and their families. A similar community development approach to midwifery is proposed within the concept of the 36-week home visit. Since giving this keynote address, an important study has described midwives', women's and their birth partners' experiences of the 36-week home visit (Kemp, 2003). The initiative was described as:

> …an alternative model of authoritative knowledge, one which acknowledged a role for intervention and technology but placed as central a philosophy of birth as a physiological, transformational and socio-cultural event (Kemp, 2003 p.4)

In her research, Joy Kemp (2003) identified a range of productive activities involved in carrying out the 36-week home visit. Based on my experience, these were summarised in Mary Smith's story: Involving family members in support in labour and in the early days following birth, with practical suggestions for how this might take place

- Discussions about approaches to being with women in pain in labour without rushing to take away pain and to ensure that physiology is promoted
- The use of photographs to encourage discussion about normal birth
- Information to reduce premature admission to hospital and choice about place of birth in labour.

Kemp's (2003) study portrayed the 36 week birth talk as an integral part of the ongoing dialogue and relationship of mutual trust that occurs between a woman and her midwife, throughout

pregnancy, where the same midwife or midwives are going to be with the woman during labour. The concept is thus directly related to continuity of care that includes an intrapartum component. It is also one element of a midwifery model that aims to focus on birth as a social, rather than a technocratic, event (Kitzinger, 2000).

The re-play of 'The birth of Jason Smith' was a rhetorical artefact designed to discuss strategies to enhance the midwifery role of 'keeping birth normal'. As this analysis has shown, the thinking behind its creation drew on a wide range of evidence to support the notion of the conference title that 'midwives can make a difference'. The contrivance attempted to address the designated task of how midwifery can flourish in a medicalised environment by suggesting a series of behavioural changes to practice. Ironically, the unspoken conclusion mirrors that of this thesis; an analysis of contemporary midwifery rhetoric suggests that midwives are only able to facilitate a social model of birth if they [re]claim a style of working that is both physically and philosophically based in the community. It is ultimately questionable whether midwifery <u>can</u> flourish within the hegemony of fragmented, hospital systems that stifle their ability to practise 'woman centred care' in a way that enriches the potential for women, and therefore their families and communities, to be more powerful.

Figure 15: Resources Matter: Top Ten Resources for Practising Midwives: Nicky Leap's Choice' *Midwifery Matters*

Components: *Rhetorical Analysis*	**PLANNING**	**RHETORICAL CONCEPTS**	**REALITY (SITUATION)**	**STRATEGIES FOR ACTION**
Planned • *Arguments, Evidence, Arrangements,* • *Aesthetics*	Conversational style Personalising advice to attract interest Sets up system to engage	• Evidence based practice • Keeping 'up-to-date' • Drawing on the expertise of practising midwives, sharing our ideas and knowledge, being a resource for each other • Practical ideas for 'keeping abreast' of new information – eg MIDIRS in the loo • Assumes that continuing professional development is a given • Looking up information with women • Each resource described with language of enthusiasm: being in the 'Top Ten' • Challenging sacred cows (complimentary therapies)	• Responding to requests for advice • Catalogues are overwhelming – where to begin • Limited budgets • Midwives love a prize • Centralisation of maternity services, threatened closure of small units • Midwives' antipathy to Academia	• Engage practising midwives who are not involved in studying • Set up system to engage practising midwives in sharing their favourite resources • Eye catching, simple style, overview of each resource • Involve midwives in evidence based practice • VBAC chosen as a common area of practice where midwives might look up evidence with women – assuming that they do this anyway as a way of suggesting best practice without assuming that they don't • Eye catching challenge: evidence for 'seventh baby at home'
Adapted to an Audience • *Values, beliefs, experiences, aspirations, social status, knowledge* • *Likely acceptance, forging links, promotion of welfare*	Targets 'practising' midwives Attempt to engage midwives in evidence based practice Recognises their expertise, Limited budget			
Shaped by Human Motives • *Commitments and motives of audience* • *My commitments, goals* • *Draw people together/promote action* • *Motives elusive or explicit*	Prize offered for others to share favourite resources Simple, non-academic style Attempts to engage midwives in ongoing process to share ideas and resources			
Responsive • *Response to a situation/previous rhetorical statement* • *Invitation to responses* • *Opposing views, constraints, circumstances*	Responds to requests, identified needs (particularly from rural and remote midwives – though not stated) Offers an			
Seeks Persuasion • *Symbol systems and resources employed*	Addresses 'overwhelming' nature of problem			
Social Functions • *Tests and refines ideas* • *Power issues/distribution* • *Evidence for decision making:* • *Knowledge/praxis* • *Build/nurture a sense of community*	'Desert Island Discs' idea to capture imagination and encourage midwives to think about what they suggest Levelling – the potential for all to be a resource for each other			

Chapter 6

Conclusion

I would like to think that any aspect of this thesis could be seen to be incorporating the element of 'curiosity' that 'evokes concern' described by Michel Foucault in an interview:

> … it evokes the care that one takes for what exists and could exist; a readiness to find strange and singular what surrounds us; a certain relentlessness to break our familiarities and to regard otherwise the same things; a fervour to grasp what is happening and what passes; a casualness in regard to the traditional hierarchies of the important and the essential (Lotringer, 1989 p.189) .

Elements of curiosity and concern have motivated me throughout the process of analysing and presenting the complex issues that I, and other midwives in Australia, face as we strategise to narrow the gap between our ideals - as portrayed in midwifery rhetorical discourse - and the realities of the professional and political constraints that challenge midwifery. All of the selected portfolio texts have elicited their own rhetorical claims in their persuasive attempts to articulate 'projects of possibility' (Walker, 1995a). The overall aim of these rhetorical efforts has been to articulate the potential role of midwives in enabling situations where childbearing women are able to experience the potential power that transforms lives (Kitzinger, 2000; Leap, 2000).

> Only if we raise our voices will the beginnings of our language be heard, and only if we share experience can we build concepts which are of use to women. (Kirkham, 1986 p.45).

The portfolio texts have contributed to the thesis with their own discursive and epistemological intent in the strategic process of defining and describing midwifery. Rhetorical innovations have been used to convince others of the changes that need to be addressed in the practice, education and regulation of midwifery as well as policy and systems development that will enable midwifery to thrive. Although the texts have their own discursive value, the analysis of their rhetorical innovation offers another layer of epistemology for those who engage in the politics of childbirth.

As identified throughout this work, the rhetoric of the Women's Liberation Movement of the 1970s and 1980s not only inspired and motivated me to change how I saw myself in the world; it profoundly affected how I have engaged with midwifery since that time. In particular, I have articulated 'woman centred care' and the imperative for midwives to come together for support, to share ideas and information and to create changes to practice and systems through collective action.

These are all concepts arising from my feminist identity, which was moulded through the creativity and zest of consciousness raising groups and the experience of living through the polemic of that movement. This identity has influenced not just what I think, but also the way in which I think, how I engage with people, and how I write.

Writing is a form of thought (Chinn, 2003), an active process that shapes ideas. Feminist principles and perspectives have influenced the way in which I have consciously taken responsibility for how the ideas in this thesis are shaped. However, I have become aware that, as part of my identity, feminist rhetoric operates on a level in my writing and thinking that is far more organic than what is readily apparent, and is therefore, difficult to identify.

I am not one of those people who can think about ideas, make a logical plan and then sit down and write. For me, the process of writing is a dynamic one that depends on the freedom to try out ideas as they surface and flow through my fingers onto a keyboard. The crafting of ideas is so directly related to the delete button and the ability to cut and paste that I can no longer write with pen and paper without making an illegible mess. In light of this, the discovery of rhetorical analysis and the subsequent development of the framework table to analyse the portfolio texts, offered an epistemological discipline that I found surprisingly exciting and useful. Instead of reducing and constraining my thinking in a restricting way, the framework opened up for me a telescopic new world of awareness.

I began to see the hidden nuances and complexities of how persuasion is always operating in my texts as a set of carefully arranged symbols (Foss, Foss, & Trapp, 2002). The framework table, designed to facilitate an analysis of how the principles of rhetoric are operating in the features of the planning, production and strategic intent of the portfolio texts, has served me well. It has allowed me to look critically at the inherent means of persuasion running through all aspects of how I engage with writing and speaking midwifery and to identify how rhetorical innovation can be used as a strategy to address problems. In turn, the framework has heightened my awareness of how I read and interpret the rhetorical innovation in the speaking and writing of other authors. I hope that this thesis will offer insights to others and that it will therefore stimulate learning opportunities through various new texts that will arise in, and from, its dissemination.

Lynne Pearce, (2004) described a similar process when she identified how the principles of classical rhetoric offer a useful framework to make visible the features of composition and thought production, in particular the production of hypotheses and arguments. Any project requires voice, a hypothesis, a framework, and a set of arguments. There is therefore value in looking to classical

rhetoric, as well as contemporary interpretations of rhetoric, as a structural model of communication (Pearce, 2004). Pearce suggests that rhetorical technique survives the centuries because it is 'effective enough to resist evolution' even when experimental ways of writing are explored (Pearce, 2004 p.13). Her claims regarding the importance of rhetoric and skilled rhetors to the survival of feminist politics could equally well apply to midwifery:

> The most talked about theoretical breakthroughs of recent years – as well as the most memorable arguments, sound bites, and debates – are inextricably linked with the rhetorical/stylistic means used to *produce* them. The link between rhetorical and epistemological innovation is, it would seem, incontrovertible (Pearce, 2004 p.212)

A range of rhetorical modes and stylistic means have been analysed for their strategic intent in this thesis. This has highlighted for me the importance of text design in the conceptualisation of a project and, ultimately, its epistemology (Pearce, 2004). Graphics such as PowerPoint presentations, photographs, and textboxes, sit within a range of texts to express and promote theoretical reflection, convey ideas and address sophisticated concepts 'purely through positioning' (Hicks, Adams, & Gilbert, 1999 p.86).

The style and modes of rhetorical innovation in the portfolio texts were designed with particular audiences in mind. I have been able to show how the planning of these texts paid careful attention to what Aristotle called 'benevolence' - a knowledge of human psychology and the ability of the rhetor to strike a sympathetic or empathetic chord with their audience. Various strategies have been explored concerning how the needs of different types of audience were addressed in the planning of portfolio texts.

Storytelling has been included in a way which allows the stories and experiences of the midwives to dialogically interact with my own in order to awaken collective empathy (Rich, 2001). Texts have also attempted to show concern for the reader through the use of lucid, accessible writing and the avoidance of alienating, dense language (Cosslett, Lury, & Summerfield, 2000). Pragmatic arguments have been linked to practical suggestions or recommendations and always, the role of evidence has underpinned the appeals I have made for change (Herrick, 2004).

Identifying how rhetorical concepts are positioned in my writing has enabled me to stand back and think about the challenges that threaten to extinguish midwifery in a culture of technocratic hegemony dominated by obstetric thinking (Davis-Floyd & Sargent, 1997; Murphy-Lawless, 1998). There have been recurring references to the 'dinosaur question' and rhetorical appeals for 'midwives for our daughters, our grand daughters', similar to the urgency suggested by Sheila

Kitzinger when arguing for women to come together to explore how we may enable a social model of childbirth:

> This is a challenge for all of us, nationally and internationally, not only for our sakes, but for our daughters, and their daughters after them. If, through fear and ignorance, we neglect our heritage and allow technocracy to take over, woman-centred childbirth may be lost forever
> (Kitzinger, 2000 p.250).

We are only just beginning to find convincing ways to persuade others that midwifery may have long-term transformational consequences for the lives of women and their families (Kirkham, 2003; Kitzinger, 2000; Oakley, Hickey, L, & Grant, 1996; Oakley, L, & Grant, 1990). This task is complicated, as identified in the delightful rhetorical phrase: 'the things that count cannot be counted' (personal communication with Murray Enkin). It is virtually impossible to measure how the relationship of engaging with women around 'uncertainty' and enabling situations in which they can feel strong and capable (Downe & McCourt, 2004; Leap, 2000) might make a difference to women's lives. I have grappled with such notions in this thesis, frequently returning to the refrain of 'woman centred care' and appealing for the development of community midwifery and the encouragement of home birth as major strategies to 'define normal in the context of pregnancy and birth; orchestrate an environment conducive to women's success in birth and other parts of their lives; and achieve outcomes beyond perinatal measures' (Powell Kennedy, 2004b Slide 5).

> Only when women and midwives build a strong and supportive sisterhood which enables women to give birth in their own way, in their own time, and in their own place, can midwifery be re-born.
> (Kitzinger, 1995 p.x).

This thesis suggests that rhetorical innovation can play an important role in bringing these concepts to life, through touching the hearts and minds (hooks, 2000) of many and thus creating a new paradigm of the social within which midwifery can flourish. When engaging with midwifery colleagues, in particular, I have attempted to imply that the audience and rhetor are part of an ongoing process of discovery, riddled with purpose and passion, which both stimulates and inspires action that will benefit childbearing women and their families in the future.

Epilogue

As I finish writing this thesis in early 2005, I find myself contemplating the positive changes that have occurred since I came to live in Australia in early 1997. Recent developments include:

- The introduction of three year Bachelor of Midwifery programmes
- A Nurses and Midwives Act in New South Wales and the first Midwifery Practice Committee in the new Nurses and Midwives Board
- Government documents that acknowledge the need to develop community based, midwifery models of care (NSW Health Department, 2003)
- Resources (Homer, Brodie, & Leap, 2001), workshops and education programmes (See Appendix F for an example) specifically designed to enable midwives to set up and work in midwifery continuity of care programs
- Increasing development of midwifery group practices and team midwifery projects, with annualised salary agreements (union negotiated)
- Commitment across an Area Health Service to develop the first publicly funded home birth projects in NSW with agreement from NSW Health Department to provide indemnity insurance
- The increasing visibility of midwifery in nomenclature in hospitals, universities and government departments and documents – it is becoming much more rare to find midwifery buried within nursing
- An increasingly strong Australian College of Midwives with a set of standards that are compatible with those of other comparable countries
- An awareness of the need to use woman friendly language in midwifery publications
- Publication of a national analysis of midwifery education, workforce and regulation (AMAP, 2003)

I acknowledge that the rhetorical discourse that I have engaged in through writing, teaching, campaigning and speaking out, has contributed to these developments, as have my various roles in leadership. However, none of the changes would have happened without the coming together of many passionate midwives: the support and sharing of ideas, experience and resources, and the strategising, rationalising and defining of midwifery that was explored in this thesis. The effectiveness of these efforts has been due to the foundational work, throughout many years, of midwives whose higher education achievements have enabled them to become strong leaders.

I have decided to end this thesis by presenting the third draft of the Australian National Competency Standards for Midwives (Appendix G), which I have been involved in developing with colleagues at the University of Technology and two other Australian universities. A process of engaging with midwives across Australia through workshops; publications; an interactive website; and now the final testing for validity in a variety of practice situations; will continue to inform the re-drafting of the competency standards as they reach their final version. I include them here because they show how the rhetorical articulation of midwifery in this thesis has been embraced by the profession – in particular the notion of midwifery as a public health strategy that is woman centred and addresses primary health care principles.

Given the hospital based, technocratic model of maternity care that is predominant throughout Australia, I suggest that midwives have embraced these competency standards as a vision document for the future and as a deliberate strategy to develop and audit 'woman centred' midwifery. The courage and determination that will accompany this effort will no doubt draw on, give birth to, and be sustained by a web of rhetorical innovation and increased skills and confidence.

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Chapter 1

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