

THE INVISIBILITY OF MIDWIFERY – WILL DEVELOPING PROFESSIONAL CAPITAL MAKE A DIFFERENCE?

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requirements for the degree of**

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CERTIFICATE OF AUTHORSHIP / ORIGINALITY

I certify that this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

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ABSTRACT

Serious questions need to be asked about the current status of midwifery in Australia. This doctorate examines the lack of recognition of midwifery as an autonomous profession and its consequential invisibility in Australian maternity care.

Despite the significant amount of evidence that continues to accumulate to support the expansion of midwifery models of care, such changes have not been widespread in Australia. An examination of international, national and local health policy and strategic direction in maternity services, together with a critique of contemporary Australian midwifery and the role of the midwife within the public health system, provide the rationale and context for the study. The 'case' for introducing improved systems and models of maternity care is developed with regard to the evidence for increasing the utilisation of midwifery. The doctorate argues for greater visibility and recognition of midwifery in Australia with a focus on the role of midwifery leadership and its potential to improve collaboration.

A number of case studies report experiences and insights of leadership and collaboration across different contexts: clinical practice, organisation of health services and health policy leadership in maternity services. The result is a comprehensive understanding of the reasons for the lack of visibility of midwifery and the potential costs of such a situation continuing. The exploration of this situation highlights the barriers to recognising and acknowledging midwifery itself.

Attention is drawn to the continuing lack of voice and visible leadership in Australian midwifery, with midwives being absent from decision-making in situations where others, predominantly nurses and doctors, speak 'for' them.

This work examines the barriers to midwives forming alliances and working to influence government agendas at the social, organisational and political level. Exploration of the power structures and hierarchical constraints that exist reveals particular barriers and highlights what is needed to address the impending decline of the profession in Australia.

The enhanced capacity that midwives would experience if their work were to be understood, recognised and valued in the provision of maternity services in Australia, is postulated through the development of a construct called 'professional capital'. Drawing on several theoretical perspectives, it is argued that the notion of 'professional capital' is dependent on a strategy of focused and deliberate

leadership and collaboration within maternity services and the creation of positive social networks and affiliations amongst midwives.

Professional capital would enable greater visibility and recognition of midwifery and a more effective midwifery contribution to maternity services. It is suggested that improved professional and societal recognition will ultimately enhance the professional performance and self image of midwives. Such developments will enable new and effective ways of supporting and strengthening inter-professional relationships and systems of care that will, in the long term, improve the outcomes and experiences of women who access maternity services.

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Midwifery is my life. The fact that I have been educated, enriched and nurtured in a myriad of ways by my work is both a gift and a privilege. Midwifery has also brought me priceless gifts in the form of life long friendships and opportunities. One of those opportunities was the chance to study my work.

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There are experiences shared in the doctorate that reflect contact and engagement with many women, midwives, doctors and nursing leaders. They are the subjects of this work. From them I have learnt so much. Women in pregnancy, labour and childbirth provide the inspiration and reason for why we must continue to improve midwifery in Australia. Ensuring that they can freely choose midwifery must be the cornerstone of future care. Midwives all over the country have contributed and enthused about the value of the work in making midwifery visible and I am grateful for the myriad of their contributions.

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1.0 PROLOGUE

I have been a midwife since 1979. My interest in the importance of leadership in midwifery and maternity services arose through clinical practice experience. Throughout my career I have worked as an activist seeking greater recognition for the capacity of midwifery. My nursing career, whilst brief in comparison, prepared me adequately for the essential knowledge areas in biological and physiological sciences. I was told I was an efficient and compassionate paediatric nurse. From day one of my midwifery education however, I knew that the role was different and that this was to be my 'calling'. I recognised inappropriate and unnecessary procedures and approaches to care of women and felt compelled to ask questions about why or why not certain practices were followed or ignored. I initially endeavoured to do this in the spirit of inquiry and healthy curiosity that befitted the role of a midwifery student. Later, through the roles of registered midwife, midwifery teacher and manager of midwifery services, I continued questioning practices and systems of care in the pursuit of better care for women. It was many years later that I connected this professional pursuit and activism with my slowly emerging feminism.

A commitment to reforming maternity services and promoting the role of the midwife soon became coupled with a desire to engage with organisations and individuals willing to explore and embrace change. This has largely determined how, and where, I have been employed. I was drawn to roles that offered an opportunity to create changes to the mainstream systems and models of maternity care, in particular those that saw the merit of greater utilisation of midwives. My philosophical belief in the potential of midwifery models has largely underpinned my employment positions for the past fifteen years. This also drove me to seek further education, knowledge and academic skills. The individual leaders with whom I have worked, and their underlying philosophy of maternity care, have also influenced my career decisions.

My experiences and those I have read about and shared with others, tell me that relationships between midwives and doctors have never been straightforward. Clear differences of power, gender, education, pay, social status and class are accepted and remain largely unchallenged. Despite [presumably] sharing similar goals, sensible debate and exploration of underlying tensions within the professional relationships of maternity care providers have been largely absent in the literature or in practice. For this reason, I chose to explore and analyse aspects of leadership

and their links to developing collaborative models of maternity care, as I have experienced and understand them. In doing so, I anticipate that these models [and this doctorate] in the future may give greater recognition and visibility to the midwifery profession.

Since 1979, I have seen many changes in philosophy, organisational structures and models of maternity service provision. I have practised in a variety of roles and learnt much from observing others in practice as clinicians, teachers, managers, academics and consultants. Some of the most profound teaching I have had as a midwife has been through watching and listening to women, particularly women who have laboured and given birth in their own homes. This portfolio is constructed in part, from my personal journey through those years, although the majority of the work has been produced over the last four years. It describes my pursuit of knowledge through my own education and the journey I have taken in seeking to raise the profile of the contemporary role of the midwife. It is underpinned by my increasing concern and despair about the future of midwifery in Australia.

Over the past decade the profession of midwifery in Australia has undergone considerable change and challenge. The move from hospital-based 'training' to tertiary-based education for midwives, which occurred over this period, was assumed to bring great potential for growth and development to the profession. This potential was related to perceived opportunities for educational and academic advancement alongside a similar process that had been achieved for nursing. The anticipated emergence of a 'new professionalism' in midwifery, associated with the transfer of midwifery education into the tertiary educational sector, was thought by many midwives to be essential to midwifery's future sustainability. This was evidenced through the various conference presentations and journal publications of the time where several of the leaders of the profession were heralding a fresh start and a new era for midwives. As a professionally active midwife I believed that the vision being proposed was achievable within my career span.

On Tuesday April 15th 1997, I was one of a group of midwifery educators, practitioners and researchers who met in Melbourne to share their views and explore ideas about the current issues affecting midwifery in Australia. An increasing level of concern was being raised by each of us. We collectively identified problems with standards of education, midwifery practice and the limited range of midwifery services available to women. To those of us who attended, it appeared that the 'vision' was not being achieved and that in fact it seemed that midwifery was 'in

trouble' professionally. Informally, through various networks, there was growing consensus that midwifery education and practice in Australia was in a serious decline locally and falling behind international standards in similar countries. This group believed that urgent evaluation and assessment was required. At this meeting, a plan was developed that included a decision to pursue funding for a major national study about midwifery and the role of midwives in Australia. At about the same time the organisation then known as 'Women's Hospitals Australia'¹ approached Professor Lesley Barclay expressing their concerns with the clinical competency standards of many newly graduated midwives. What followed was a funding proposal, developed by researchers from the fields of midwifery, nursing and sociology [and several of us from the original meeting in Melbourne], who engaged five separate industry partners, including Women's Hospitals Australasia in their concerns. In addition to Women's Hospitals Australasia the other industry partners were: a large area health service, two state health departments and the Australian College of Midwives who all agreed to commit funds to support research to study midwifery's contribution to contemporary Australian maternity care. This research became known as the Australian Midwifery Action Project.

The Australian Midwifery Action Project (AMAP) subsequently received funding from the Commonwealth government through the Australian Research Council as part of its 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. The research was projected to take three years to complete. Commencing in April 1999, the project was set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services. The overall aim of the AMAP study was to conduct an analysis of the effects of recent changes in maternity care policies, current midwifery regulation and educational systems as well as to investigate models of care and practice. The design of the study enabled the doctoral research training of two midwives, who would simultaneously conduct the study under supervision and receive concomitant post-graduate research training. I was one of the two full-time midwifery researchers engaged to undertake the AMAP study as part of a Professional Doctorate in Midwifery.

¹ Later known as 'Women's Hospitals Australasia'

1.1 INTRODUCTION

This portfolio conducted over the period from 1999 to 2003, was produced in part as a result of my work on AMAP. It examines the invisibility of midwifery in maternity care in Australia. The work first identifies the problem through the conduct of three discrete pieces of empirical work. These provide evidence to substantiate the claim that currently in Australia there exists a lack of recognition of midwifery within the provision of mainstream maternity care. The portfolio then proceeds to report and analyse the use of a number of strategic actions, which I undertook in order to address the problem. In the final section of the portfolio I present an essay that links leadership as a strategy to develop a concept, which I call 'professional capital'. This, I believe, is the overarching strategy necessary to address the invisibility of midwifery within Australian maternity service provision.

'Professional capital' is the term I have chosen to describe the potential enhanced professional capacity that midwives may experience if they were more visible, recognised and valued in the provision of maternity services in Australia. I have developed the concept from an understanding of 'social capital' (Putnam, 1993), a construct used to describe the benefits that emerge from positive social networks and affiliations. These effects include the capacity to improve functioning of individuals, networks and relationships that in turn can lead to new and creative ways of supporting and strengthening interpersonal relationships. Like other forms of capital, professional capital is 'productive' (Coleman, 1988), which may make possible certain professional achievements and outcomes that would not otherwise have been thought possible. Social capital is often described as a feature arising as a by-product of the social relationships (Achat, Kawachi, Levine, Berkey, Coakley, Colditz, 1998). Thus through leadership, enhanced professional capital may provide the capacity and visibility for midwifery that is so urgently needed within the Australian setting.

One of the main leadership approaches applied within this portfolio is similar to that described by Rosener as 'transformational' leadership' (Rosener 1990). According to Rosener, leaders who possess transformational characteristics are highly appropriate within the current context of service provision, which requires effective change management within health care services (Rosener, 1990). Such characteristics include the capacity to be innovative and creative and to bring into existence new structures, systems and processes. This form of leadership requires an engagement of two or more individuals in interactive processes. These

processes are meant to bring about increasing motivation focusing on progress, achievement and relationships (Rosener, 1990). This is indicative of the approach used in several parts of this portfolio. It is the type of leadership that is clearly important for midwives who are simultaneously required to form partnerships with women (Guilliland and Pairman, 1995), and to work collaboratively with a range of different health professionals in order to provide appropriate care. Bennis (1989) argues that the critical link between strategic vision and effective leadership is communication. In identifying the link between leadership and language, he suggests that it is effective communication skills, which energise, inspire and motivate others (Bennis, 1989). Later in the portfolio I show how I used communication through reports as the President of a professional association, as a specific leadership strategy designed to inspire and motivate midwives.

The portfolio is based on my conceptualisation and vision for a type of 'new midwifery' for Australia building further on the work of Lesley Page in the United Kingdom (Page, 2000). This conceptualisation is based on a number of assumptions about midwifery in this country, which I feel I am able to make, due to my experience in the field. Throughout the course of the portfolio I engage the reader with evidence from a variety of sources to underpin these assumptions. The first of these is that midwifery is invisible within mainstream maternity services and the health care system generally, in Australia. Using a number of different sources of data and approaches, the lack of visibility of midwifery within maternity services and within midwifery educational and regulatory structures is identified, explored and analysed. Later it will be argued that the lack of visibility of midwifery can be reversed through the development of professional capital, which can be achieved through a strategy of leadership.

The second assumption is that leadership in practice, organisations and development of policy in the health services is essential to achieve the necessary and recommended reforms in maternity care. It will be shown that currently there is a lack of leadership of maternity services. Significantly, leadership that promotes the role and benefits of midwifery and the importance of a collaborative approach to practice, service provision and policy development will be confirmed as lacking. In addressing this problem, a number of strategies for increasing the recognition and contribution of midwives will be presented. These include several leadership strategies to improve collaboration, maximise midwifery's contribution to maternity care and influence the development of professional capital in midwifery.

The overall aims of the portfolio are to explore the following propositions:

- That midwifery is invisible in Australian health care and that this has consequences for the outcomes of mainstream maternity service provision
- That a number of strategies for increasing the recognition and contribution of midwives are important in addressing the problem and can be readily implemented
- That leadership can influence the development of professional capital in midwifery and produce effective collaboration that is necessary to improve maternity care

The portfolio is set up in the following way:

An introductory and background section sets the scene through a critique of contemporary Australian midwifery and maternity services development and attempts at reform in the organisation of maternity services. The role of midwifery as distinct from nursing and the status of midwives within the medicalised hierarchy of maternity care providers is described. Systems and models of care are outlined within the international, national and local health policy frameworks. In this section it is shown that despite a growing body of high quality evidence that recognises the potential of the midwife as a significant and important contributor to maternity services, the role has neither been well recognised nor supported nationally. Support for the expansion of midwifery models of care for the most part, has not been forthcoming. It is evident from this critique that a number of barriers to the introduction of new models of maternity care exist and that part of the problem, are in fact barriers to midwifery itself.

Section One confirms the problem of midwifery invisibility through the reporting of a number of separate studies. The first study, referred to as 'The midwives' voices study' was conducted with a cross-section of Australian midwives, most of whom were in current practice. Participants were asked in a national survey: 'What are the barriers to midwifery'? These data provided evidence of the current issues affecting the profession. Through an analysis of these responses, significant concerns are identified regarding the organisation of maternity care, the lack of recognition of midwifery and the lack of leadership that is necessary to bring about change.

The second study reports on empirical research conducted to examine the regulation of midwifery in Australia. Through an analysis of each of the Nurses' Acts in each of the Australian states and territories, the problem of midwifery invisibility is

reflected. There are also serious concerns regarding inconsistencies and inadequacies of the current legislation identified, all of which serve as additional barriers to midwifery itself.

The third study explores the problem of invisibility of midwifery as it arises in practice and policy. Through the reporting of experiences and insights gained in the analysis of three case studies, the role of leadership and collaboration in maternity services and the consequences of a lack of leadership are examined and interpreted through a critique of the prominent theories relating to leadership and collaboration. Within a context of widespread national and state based health policy change, and the introduction of flexible models of maternity care, midwifery's contribution and capacity to adapt to necessary changes and challenges is assessed through these case studies. The frameworks of Primary Health Care (World Health Organisation, 1986) are used to explore the current problems in maternity services, which have arisen in part as a result of their shift away from primary health care to an acute hospital focus of care (World Health Organisation, 1995). The impact that these changes are having on the integrity and capacity of midwifery to contribute effectively to the care of women and the nature and quality of the services they receive is also examined.

The case studies arise from my own experiences in practice across three different contexts of health services leadership: clinical practice, organisation of health services and health policy leadership. These were chosen for their contrasting features and dimensions. The case studies identify the multiple attributes and strategies that are necessary to assist the profession, policy makers and service providers in Australia to adapt and change current models of care and the practice of midwives. Through the case studies, it will be argued that the needs of Australian women for high quality maternity services and increased recognition of midwifery are mutually achievable through leadership and the development of professional capital in midwifery.

Section Two describes techniques to make midwifery visible. This section includes several strategic actions that flow on from the identification and defining of the actual problem. The first action consisted of a strategy aimed specifically at reforming the legislation and regulations governing the practice and education of midwifery in one state of Australia, that is, New South Wales (NSW). This was a strategic move that was purposely designed to gain visibility through the legal recognition of midwifery in that state. The action involved the preparation of a

submission to the Review of the Nurses Act 1991 in 1999. As the leading author, I argued the need for greater visibility and recognition of midwifery within legislation. The process of leadership that was used and the outcomes of the submission and their implications for the midwifery profession are also discussed.

The second action was the implementation of a leadership strategy involving the profession of midwives who were members of their professional organisation, in one Australian State. [This developed in part as a response to some of the findings from the midwives' voices study]. The leadership strategy consisted of regular President's reports that were designed to encourage and stimulate midwives into action and achieve greater visibility and recognition. The reports were presented in the form of a 'call to action' to the profession, at a time when many challenges and opportunities for greater visibility were being put forward. Along with a series of different political media activities, including radio interviews and newspaper articles, this strategy was designed to raise awareness of the areas of concern and engage midwives and others in understanding the issues and seeking ways of addressing them. The aim, process and outcomes of this strategy provide a case of midwifery leadership in action that may benefit others.

The third action involved the testing of one possible solution to the problem of midwifery invisibility through the application of some lessons learnt from both practice and empirical studies. This involved testing leadership midwives that sought to build collaboration amongst maternity care providers and increase the potential for improved outcomes of care. This case study describes my shared role with two other colleagues that led to the introduction of a short educational course into Australia for the management of emergencies in maternity care. This case study of leadership in action is used to demonstrate a practical example of the promotion of collaboration in maternity care and the concomitant rising of the profile, status and arguably, the professional capital of midwives that followed.

Section Three presents a way forward and some prospective solutions to the problem of invisibility of midwifery by developing professional capital through leadership. An essay undertakes an exploration of leadership as a strategy and collaboration as a process to build professional capital. This is combined with an analysis of theories of leadership and collaboration as applied to contemporary maternity service provision. In this final section, the potential to reform and reconstruct midwifery as a profession in its own right in Australia is explored through

a synthesis of the barriers as well as the possible solutions identified through the portfolio.

2.0 BACKGROUND TO THE STUDY

In the next section the context and background for the study is presented. National and international maternity services policy and strategic directions provide the backdrop to an analysis of the role of the midwife and the barriers to the fulfillment of the role in Australia. The safety of midwifery and the rationale and importance of making midwifery visible is demonstrated along with the evidence for the introduction of models and systems of maternity care that increase the utilisation of midwives.

2.1 AUSTRALIAN MATERNITY CARE

In Australia, there are approximately 250,000 live births annually (Australian Bureau of Statistics, 1997). The majority of these births take place in hospitals staffed by approximately 13,800 registered midwives and nurses working in maternity units (AIHW, 2002), with medical care available either 'on call' or 'on site'. High standards of maternity care are based on the assumption that there is, and will be, the availability of qualified midwives for all women during labour, birth and the initial postnatal period. Whilst there are clearly areas for significant improvement, childbirth in Australia is considered relatively safe compared to international standards with a fetal death rate of 6.7 per 1,000 live births (Kitzinger, 1988). However, in Indigenous communities the fetal death rate remains nearly double that at 12.5 per 1,000 births (Kitzinger, 1988) and the proportion of low birth weight babies (under 2500 grams) born to Indigenous women has remained two to three times higher than for non-Indigenous women (AIHW, 2001; Kitzinger, 1988). A recent report on maternal deaths in Australia reported the first recorded increase in maternal deaths since the 1970s with deaths of Indigenous mothers three times the national average (Barclay, Brodie, Lane, Leap, Reiger, Tracy, 2003).

Currently, maternity services in the Australian public health sector are predominantly hospital-based and provided by a range of different health professionals. Most women see a number of different health care providers (midwives, obstetricians, GPs) through their pregnancy and are attended by different caregivers during labour and birth and again during the postnatal period. It is not uncommon for a woman to see as many as thirty different health professionals through the course of her pregnancy and childbearing experience in the public health system. Over the past 15 to 20 years various models of maternity care have been developed through local or historical patterns. These are generally based on demand for services and availability of an appropriately skilled workforce.

Like most comparable western countries Australian maternity services are largely influenced and controlled by obstetrician led planning and decision making. National data shows that 33% of women access private obstetric care, either as private patients in public hospitals or by choosing to birth in a privately run maternity facility (AIHW, 2001). The majority of public maternity care is hospital-based and funded through the acute health services budget of the States and Territories. In addition under the 'Medicare' system of health care funding, the Commonwealth provides a 'fee for service' for 'items' of obstetric care provided by general practitioners (GPs) and obstetricians as primary care providers in the public health system. This includes antenatal care, care in labour and birth and the postnatal period including the postnatal review at six weeks postpartum. In Australia, there is no funding for primary care provided by midwives from either the state or Commonwealth health care budget allocations. In urban settings, women usually have access to free maternity care through the public hospital system where they mostly see a range of different health professionals including midwives and staff obstetricians, GPs, residents and registrars (Homer, Davis, Brodie, 2000). In addition, there are reports of some women receiving care from registered or enrolled nurses (Brodie, 2002). Within and between public and private hospitals there exist large differences in style, philosophy, practices, resource utilisation and adoption of evidence based policies and protocols. In rural locations, many small units are faced with closure due to lack of twenty-four hour obstetric and anaesthetic medical cover (AMWAC, 1998). Those that continue to provide maternity services encourage access to antenatal care (either shared care or in total) with the general practitioner rather than hospital based clinics. This enables a degree of cost shifting from the state (hospital based) budget to the Commonwealth (Medicare) funds.

Within the public maternity system care is fragmented across the antenatal, intrapartum or postpartum periods. There have been numerous suggestions that the current system is not acceptable to many women (Shearman, 1989; Commonwealth Department of Health and Aged Care, 1999) (Maternity Coalition, 2002). Fragmentation is further compounded by an increasing promotion of 'shared care'² in the antenatal period and a range of different protocols and procedures that influence the various forms of care and services available (NHMRC, 1996).

² The provision of care that is shared between general practitioners, obstetricians, midwives and/or Aboriginal or Torres Strait Islander health workers (Homer, Brodie and Leap 2001).

2.2 INTERNATIONAL HEALTH POLICY STRATEGIC DIRECTIONS

Global changes in maternity service provision should be seen within the context of the widespread health care reforms occurring in nearly all industrialised countries. Since the 1980's, organisational and structural change in the public sector have heralded massive policy review, analysis and redirection which particularly affects health care services, given their centrality and predominance in overall public sector expenditure. Under the umbrella of Primary Health Care (World Health Organisation, 1978; World Health Organisation, 1981; World Health Organisation, 1986) health care services are being reoriented towards a system which is:

“... an integral part both of the country's health system of which it is the central function and focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the National Health System bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”

(World Health Organisation, 1978)

The WHO coined the slogan 'Health for all by the year 2000' in 1978 to reflect the global strategies, which were adopted at that time by its international members. The Australian Government was a signatory to these policies. Thus, 'Health for all' is an international movement, which aims to ensure that more people have healthier, longer lives free from disease and disability. Achievement of these objectives at international, national, state and local level requires all health professionals to become familiar with the fundamental principles of Primary Health Care. It will be of paramount importance that these principles are used as a conceptual framework not only for maternity services planning, organisation and delivery, but also as the underpinning for education and training of the health care workforce. In simple terms, these principles imply that:

- Health care services should be equally accessible
- Maximum individual and community involvement should occur
- The focus should be on illness prevention and health gain
- Only appropriate technology that is scientifically valid and adapted to local needs is used and this is affordable and acceptable to the community that uses it

- Health care is only one aspect of total health development; education and housing and nutrition are all essential to overall well-being (World Health Organisation, 1978; World Health Organisation, 1986)

Applied to maternity care primary health care principles mean that services need to be reoriented towards a community basis with care available and accessible close to where women live and work. A shift in the philosophy of care towards a 'social' rather than a 'biomedical' approach is necessary with an emphasis on primary prevention and enhancing health gain. This is achieved by ensuring the availability of primary, secondary and tertiary maternity services that enable a seamless transition through the necessary levels of care, from home to the acute service and home again, for women and their babies. In this context midwives, GPs and Indigenous health workers will provide the bulk of care for women who are experiencing a normal pregnancy and anticipating a normal birth.

The Ottawa Charter (1986) defines health promotion as the process of enabling people to increase control over, and to improve their health. This, the charter asserts, can be achieved through a combination of healthy public policy (with sensitivity to education, transport, agriculture), the creation of healthy environments, community action and the development of individual's personal skills (World Health Organisation, 1986). The Charter originated as a result of concerns that more investment by government in health care was not likely to achieve the improvements in health that other social change and the commercial world might achieve (Leeder, 1999). Subsequent to this, has been development of a critique of health care policy and systems that reveals a move beyond a preoccupation with paying for health care, hospitals, doctors fees and health insurance associated primarily with those who are sick (Baum, 1999; Commonwealth Department of Health, 1993; Legge, 1999).

Since the middle of the 1980s in most industrialised countries, there has been a redirection of health policy towards health improvement and maintenance. This has involved much greater emphasis on achievement of health outcomes in relation to goals and targets, along with increasing recognition of the influence of 'social determinants of health' (World Health Organisation, 1986; Better Health Commission, 1986; Commonwealth Department of Health, 1993; Legge, 1999). The midwifery profession has sought to place itself centrally within a reorganisation of maternity services that reflects this new direction. In line with increasing evidence of the necessity of such an approach midwives have argued that they must become

more visible and recognised as key providers of a social, public health model of maternity service provision (Kaufmann, 2000; Kaufmann, 2002; Walsh and Newburn, 2002; Tracy, 2003)

2.3 SOCIAL INFLUENCES ON MATERNITY CARE AND MIDWIFERY

According to Legge (1999), social determinants of health are commonly identified as:

- Material factors such as access to resources or exposure to hazards
- Social and cultural factors such as social cohesion and level of education
- Emotional and psychological factors such as being in control of one's life and having a sense of belonging

Some social determinants are individual factors (being in control of one's life); some are group factors (social cohesion); and others could be constructed as either individual or group factors (eg exposure to material hazards) (Legge, 1999). These various factors are all subject to debate regarding their relative importance, how they are best theorised and the mechanisms through which they affect health and health outcomes. Midwives would argue that their philosophical approach of 'woman centred care'³ is central to their practice and what distinguishes their role from that of doctors or nurses. 'Woman centred care' focuses care around the woman in her individual social milieu with an emphasis on improving outcomes related to those particular social factors that are known to affect outcomes.

One way of theorising and measuring the influence of social factors on health outcome is through the concept of 'social capital'. Putnam (1993) refers to 'social capital' as:

"... the features of social organisation, such as networks, norms and trust, that facilitate co-ordination and co-operation for mutual benefit.

³ In midwifery, 'woman-centred care' is a concept that implies the following: Midwifery focuses on a woman's individual, unique needs, expectations and aspirations, within the recognition of her particular social milieu, rather than the needs of the institutions or the professions involved. Implicit is the notion that 'woman-centred' encompasses the needs of the baby, and the woman's family, her significant others and community, as identified and negotiated by the woman herself. Midwifery recognises the woman's right to self-determination in terms of choice, control and continuity of care from a known or known caregivers. Midwifery follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary. Midwifery is 'holistic' in terms of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations (Australian College of Midwives Inc., 2002)

Social capital enhances the benefits of investment in physical and human capital"

(Putnam, p.1,1993)

In Australia, Eva Cox further enhanced understanding of the benefits gained from embracing the concept of social capital, locating it in the world of human relationships, advocacy and politics (Cox, 1995). Cox draws a useful distinction between social capital and other forms of capital (such as financial and physical capital), which can be used to produce wealth, as can one's individual skills. It is a potentially powerful notion to conceive that, if this philosophy was accepted by the community at large and adopted by health professionals and politicians, there would be capacity for real improvement in Australia's health. This could occur within a health system that would be viable and economically sustainable. Stephen Leeder, an eminent Australian medical and public health leader, has written critically of the need to determine an agenda for action, based on an understanding of the value of social capital and how it is linked to health gain, through the formulation of health policy (Leeder and Dominello, 1998).

Various principles, strategies and styles of practice have been developed to address the 'social determinants of health' in a range of different sectors of public health. These health development principles include inter-sectoral policy collaboration; community development and empowering styles of health education (Legge, 1999). All are widely deployed at least rhetorically; most commonly with a view to changing the social conditions which frame the potential for health or ill health. Such initiatives have been practised in some communities for many years, well before the Alma Ata and Ottawa conventions, and reflect individual's commitments to partnership and the development of empowering approaches to enable people and communities to survive, develop and flourish (Friere, 1971). In Australia, contemporary maternity services are being challenged to embrace a number of social policy initiatives that are designed to focus more on the social determinants of health and strategies of health development (NSW Health Department, 2000b; NSW Health Department, 2002; Commonwealth Department of Health, 1993; NHMRC, 1998b). These are recommended as part of early intervention rather than an acute illness or symptom focus (NSW Health Department, 2002).

In this portfolio, 'health development' strategies (Legge, 1999) provide a useful framework to analyse the organisational changes that are driving reform and reorganisation of maternity care in Australia. Health development strategies

encompass a range of principles, strategies and styles that aim to address the social, economic, political and cultural influences on health outcome. These strategies are commonly directed at achieving long-term gain, rather than an immediate fix. This is particularly so where the conditions for poor health are embedded in history and social relations, as in the case of Aboriginal perinatal health, or in the distribution of power and income as in the case of socio-economic inequalities (Wilkinson, 1996). More recently, by way of revisiting Alma-Ata (1978), some Australian state governments are articulating strategies designed to focus more on 'groups' needs rather than on 'individuals', as a way of improving effectiveness (Schrage, 1990).

Internationally, 'best practice' maternity care recognises the effects that low socio-economic status can have on the health outcomes of women and their infants and the positive effects that health development strategies (Legge, 1999) can achieve in maternity care. 'Best practice' in maternity care is increasingly being defined as care that provides for the best possible outcomes for women and babies not only in terms of clinical safety and effectiveness but also with regard to improving women's lives (Kaufmann, 2000; Reid, 1997; Seguin, Therrien, Champagne, Larouche, 1989).

All of these principles and philosophical underpinning could be interpreted and applied to form a framework of maternity services and 'new midwifery' in the future. Within a context of 'woman-focused' maternity care, this 'new midwifery' would ensure that:

- Maternity care services are equally accessible.
- Women's rights as consumers including their rights to information and choice are recognised, with greater participation by women, in care that involves them as active partners. Women should be involved in decision making about maternity services planning, provision and evaluation.
- The philosophy of maternity care reflects a social context of health and encompasses the diversity of a woman's life; recognising that pregnancy and childbirth are in the majority of cases normal life events requiring minimal intervention. Childbirth and mothering are but two aspects of a woman's overall life experience and care received during this time may have a profound and prolonged effect on long-term well-being.

- Policy, services and practices are based on accurate data and current evidence, including technology and interventions that are scientifically validated, affordable and acceptable to the community that uses them.

The United Kingdom (UK) has tried to grapple with, and achieve, major improvement in maternity service provision whereby care is being reorganised to ensure that the majority of services for healthy women are community based and provided by midwives and GPs. These reforms are based on evidence and recommendations provided to the House of Commons, which led to the release of the 'Changing Childbirth Report' (Department of Health Expert Maternity Group, 1993). This reform is occurring within a framework of three basic principles: choice, control and continuity. These over-arching and all encompassing terms reflect the UK government's expression of primary health care as the necessary foundations for safe, affordable, efficient, evidence based maternity care that meets the needs of women and communities. In this setting midwifery is seen as the foundation of care and central to a primary health care approach for all maternity services.

2.4 MIDWIFERY AS PRIMARY HEALTH CARE

The acceptance of the declaration of Alma Ata (World Health Organisation, 1978) by the Australian government provides an opportunity at least theoretically, for midwives to reclaim their primary role in maternity service provision. The philosophical principles of 'primary health care' namely: equity of access; individual participation and self reliance; use of only socially acceptable technology; health promotion and disease prevention; political action to achieve change and cooperation between agencies and key stakeholders (World Health Organisation, 1986; Wass, 1994) provided an appropriate conceptual framework on which to base the reforming of maternity services. As Tara Kaufmann, Head of Policy for the Royal College of Midwives in the UK has reasoned, these foundations could underpin the reorganisation of maternity services and restore the midwife to the rightful position as the most effective provider of maternity care for the majority of women (Kaufmann, 2002).

In so doing, improved public health and long term health gain, key outcomes of the new public health agenda (Newburn, 2001; Downe, 2001) could arguably be realised. This will only occur if midwives are able to practise to their full capacity, maximising women's capacity to labour and birth physiologically without unwarranted and costly intervention (Downe, 1997).

Over the past ten years in Australia, these philosophical principles have begun to have an impact on the organisation, planning and provision of mainstream public hospital based maternity services. This is evidenced by the direction provided through national and state government health policy.

2.5 NATIONAL AND STATE GOVERNMENT HEALTH POLICY

In 1993, following an extensive review and strategic planning process incorporating options for change, the Australian government released the National Health Strategy (Commonwealth Department of Health, 1993). The strategy emphasised the need for the Australian health system to change, in response to changes in the community's needs and contemporary health care practices. These changes included:

- Emphasis on ongoing care across services agencies; continuity of care;
- Shorter lengths of stay in hospital;
- Increased use of non in-patient and community care;
- Pressures for improved productivity and efficiency in the delivery health care.

The strategy, which is still current, covers a range of issues in health care provision, and therefore maternity service provision, some of which include:

- Workplace reform and attention to best practice;
- Increasing attention on consumer focus and participation;
- Greater attention on the health needs of a multi-cultural population;
- Specific attention to the needs of people in rural and remote Australia, including Aboriginal and Torres Strait Islander peoples.

The report further notes that most Australian states and territories could achieve a greater integration and degree of inter-sectoral collaboration than presently exists between some or all hospital, community health and child health programs and that such integration has been partially inhibited by 'differing work practices' (Commonwealth Department of Health, 1993). Applied to maternity care, it could be argued that the ongoing basis for the organisation of services has been upheld by history and tradition with 'differing work practices' of midwives, obstetricians and GPs continuing to present a barrier to innovation and effectiveness. This portfolio will examine these differences and argue that the ongoing lack of visibility of

midwifery has served to inhibit the potential for improving outcomes for women in particular those experiencing socio-economic inequalities.

As a part of the National Health Strategy in Australia (Commonwealth Department of Health, 1993), specific *goals and targets for seven health priority areas were identified*. These were endorsed by all states and territories as a platform for strategic planning of women's health services, including maternity care. Priority Issue One: '*Reproductive Health and Sexuality*', identified eight goals with a range of strategies that have relevance to the planning and provision of health services to women. Goal 1.2 '*Improve the range of Maternity Services*' was developed in response to demand by women for a less interventionist and more sensitive approach to childbirth. In this policy framework, strategies for the health system are action-orientated and advocate changes to the range of services provided and the manner in which services are delivered. In particular, strategies focusing on the development of a maternity service and professionals that are more able to meet the needs of women include:

- Increase the availability of midwifery based services;
- Increase the range of services available to women by funding special programs in hospitals;
- Through legislative change, remove legal and other institutional barriers to give hospital visiting rights to accredited independent midwives;
- Develop and implement models of quality care, which are sensitive to women's varying needs i.e. social, cultural, emotional and physical.

In addition, several other goals contain strategies for reform that have relevance to maternity services including:

- Increase culturally appropriate services – language, education, service providers, community involvement, antenatal care, birthing services and postnatal services;
- Develop outreach midwifery services for 'high-risk' women from non-English speaking backgrounds.

(Commonwealth Department of Health, 1993)

The National Strategy also incorporated the existing National Women's Health policy (Commonwealth Department of Health, 1993) which in 1990, had seen the allocation of \$6.44 million from the Commonwealth Budget to assist state and

territory governments to establish alternatives to mainstream hospital based maternity care. Known as the Alternative Birthing Services Program (ABSP) (NSW Health Department, 1998), objectives for Phase One of the ABSP program were:

- To promote greater choice in birthing services through the establishment of appropriate midwife managed birthing services apart from the specialist hospital setting;
- To provide an incentive to assist States and Territories to reorganise the services to achieve more cost-effective delivery and longer term improved use of health services;
- To recommend in what form an Alternative Birthing Services Program should continue.

The philosophy of care underpinning the Alternative Birthing Services Program reflected recognition of the midwife's role as primary care giver and a principle that in most cases, pregnancy and childbirth are normal life events requiring minimal intervention (Commonwealth Department of Health, 1993). This was the first formal effort within public health policy that midwifery needed greater visibility and recognition. It could be argued that such a deliberate emphasis on the benefits of midwifery provided the platform for subsequent initiatives involving a more significant and visible role for midwives in Australia. In the second phase, a further principle: 'to ensure women are involved as active partners in birthing' was introduced. This philosophy of care reflected global primary health care principles, which were also reflected in the National Women's Health policy principles (Commonwealth Department of Health, 1993). Principles, which included the importance of health services related to:

- Reflecting a social context of health;
- Encompassing of a woman's life span and roles;
- Requiring greater participation by women in decision making;
- Recognising women's rights as consumers;
- Ensuring women's rights to information;
- Developing policy based on accurate data.

The policy direction of the Alternative Birthing Services Program elevated the role of the midwife and promoted a social model of health care and pregnancy and

childbirth as predominantly normal life events. The Program sought to involve women actively in determining their own health care needs, forming partnerships with midwives and making informed decisions about choices in care. In broad terms, this led to an expansion of the range of maternity care options available to certain women and a small but significant increase in the availability of 'midwifery led' care. In 1989, the Commonwealth allocated \$AUS2 million to one State's Health Department for implementation of Phase One of the ABSP. These funds were allocated to:

- Birthing Centres as one-off capital grants;
- Midwives' salaries and;
- Aboriginal Medical Services in non-government sectors.

As part of the funding terms, all states and territories were to evaluate the implementation of their projects assessing the outcomes for women using these services. The New South Wales (NSW) ABSP Evaluation Report (1992) provided a comprehensive analysis of the effectiveness of state-wide funded strategies. This Report found that women and midwives had a very positive response to Birth Centres and that these centres were heavily booked. Significantly, in the final report, there was a recommendation that some of the principles of birth centre care could be adapted in mainstream maternity services for the benefit of more women (International Council of Nurses, 1992).

Phase Two of the Alternative Birthing Services Program commenced in 1993/94 with the allocation of \$8.9 million nationally over four years. As with Phase One, the philosophy of woman centred maternity care was a guiding principle for implementation and distribution of funds. Program objectives for Phase Two of ABSP were:

- To promote greater choice for birthing for women in the public health system through contributing to the establishment of services that are: midwife based; recognise that pregnancy and childbirth are in the majority of cases normal life events requiring minimal intervention; involve women as active partners; and provide continuity of care;
- To provide an incentive to States to trial models of care which in the long term may become part of the standard range of services;

- To encourage States to develop appropriate models of maternity care for Aboriginal and Torres Strait Islander women with a special emphasis on antenatal and postnatal care and;
- To promote awareness and understanding of a range of birthing options among consumers and health care providers.

(NSW Health Department, 1998)

The Second Phase of the Alternative Services Program in New South Wales commenced in 1993/94 with the allocation of \$2.3 million. As a result of the priorities identified in the evaluation of phase one (International Council of Nurses, 1992) it was determined, that the main focus in that state would be the development of appropriate models of maternity care for Aboriginal and Torres Strait Islander women, with a special emphasis on antenatal and postnatal care. Two one-off projects also received funding and these were:

- Maternity Alliance (Inc) in 1995 received funding for a national conference from which a 'Birthing Services Network' was formed
- Aboriginal Medical Services received funding to conduct two one-day information forums in 1994 and 1996 on ABSP and National Women's Health Policy projects
- The Evaluation of the NSW ABSP – Second Phase (NSW Health Department, 1998) focused on the nine projects funded for the development of appropriate models of maternity care for Aboriginal and Torres Strait Islander women.

Key findings included:

- That Aboriginal health workers and midwives play a key role in linking women into mainstream services and that the Aboriginal health worker is vital to ensuring Aboriginal women understand their care;
- ABSP funded projects had succeeded in developing services that were trusted by Aboriginal women and that were culturally appropriate;
- Midwives and other health care providers need training to assist their understanding of cultural issues surrounding the provision of care to Aboriginal and Torres Strait Islander women;
- Midwives face a number of barriers in providing continuity of care across pregnancy, labour, birth and the post partum period including gaining access to

the delivery suite and opposition to midwifery models of care, by some medical practitioners;

- Some Aboriginal Medical Services reported a lack of consultation and involvement in the development of strategic planning for maternity services;
- There is a need for the relevant agencies and service providers to cooperate and collaborate to ensure the successful implementation of continuity of care. This includes the need to develop relationships and structures that facilitate collaborative planning and equitable access to mainstream services.

(NSW Health Department, 1998)

The ABSP was established to promote greater choice in birthing services for women through the establishment of midwife-led birthing services that offered an alternative to mainstream medically led and hospital oriented models of care. As such it provided a vehicle for enabling greater visibility and recognition of the contribution that midwives make to mainstream maternity services. It was intended that the Program would enable the funding of homebirth as well as other alternative forms of care. This goal was not achieved with reports from one researcher suggesting that this was due to well organised resistance from the medical profession and the limited capacity of government to implement policy that confronts the power base of the medical profession (Andrews, 2000).

Across Australia, through the late 1980s and 1990s, a number of government reports recommended change and reorientation of maternity services to ensure increased continuity of care, greater utilisation of midwifery skills and relocation of maternity services towards the community (NSW Health Department, 1989; Victorian Department of Health, 1990; Fraser, 2000; South Australian Health Commission, 1995; NHMRC, 1998b). Citing evidence of consumer support for 'midwifery led' care, two National Health and Medical Research Council (NHMRC) reports have stressed the importance of continuity of care, within the context of improved quality and cost effectiveness, and the need to maintain safety and efficiency (NHMRC, 1996; NHMRC, 1998b)).

During the period 1997 – 1999, in NSW a strategic planning project for maternity services was conducted by the NSW Health Department as part of that State's ongoing commitment to the development of more 'woman centred' effective models of maternity care (NSW Health Department, 2000b). I was the Policy Analyst and Project Officer attached to this initiative and through this role I gained valuable

knowledge and education and provided leadership in the development of the strategic plan for maternity services state-wide.

All the State and Commonwealth reports and policy initiatives mentioned earlier demonstrate the respective government's responsibility for the development of policy for maternity care that reflects the principles of Primary Health Care (World Health Organisation, 1978) and focuses on public health improvement. This is particularly emphasised for women from disadvantaged backgrounds (NSW Health Department, 2002). These changes to the organisation of maternity care in Australia reflect international moves where increased costs, lack of improvement in outcomes for those at greatest psycho-social disadvantage, women's overall declining satisfaction with maternity services and considerably increased morbidity attached to intervention rates, are forcing a closer examination of medically dominated systems of care (Lane, 2001; Graham, 1997; Lilford, 1993; Roberts, Tracy, Peat, 1999). It is increasingly becoming recognised that health services need to accelerate the development of midwifery-based models of care and the leadership of midwives in providing care for healthy women. This portfolio provides a rationale for this, examines barriers to progressing with implementation and provides a strategy to address the problem of the invisibility of midwifery in Australian maternity care.

Policy directions at national and state level have been influenced by the broader international directions for health service development as has been discussed, however arguably more significant, has been the emergence of a rapidly expanding body of evidence to support greater recognition and responsibility for midwives and the benefits of a primary health care approach to the organisation of mainstream maternity care. These factors are examined in the following section where the argument for urgent reform of Australian maternity services is presented along with the scientific basis for increasing the contribution that midwives make to mainstream maternity service provision in Australia.

2.6 THE ROLE OF THE MIDWIFE IN AUSTRALIA

The World Health Organisation (World Health Organisation, 1996) states:

'The midwife appears to be the most appropriate and cost effective type of care provider to be assigned the care of normal pregnancy and birth, including risk assessment and the recognition of complications'.

(World Health Organisation, 1996)

Historically in Australia, midwives fulfilled the full breadth of their role within this WHO definition until as recently as the 1930s, when at that time they provided care for 18% of all women (Adcock and et al, 1984). Since then, the role of the midwife, apart from that practised in remote parts of the country, has been controlled, overseen and most often 'dominated' (Willis, 1983) by medical practitioners. The only other exception to this currently is the small and diminishing numbers of independent midwives, [who in 2000 lost access to affordable professional indemnity insurance] and the handful of innovative public hospital programs that are seeking to introduce midwifery 'caseload' models of care (Homer, Brodie, Leap, 2001).

In Australia, midwifery was always a separate profession (Barclay, 1986) until it was subsumed into the nursing profession with the introduction of nurses' regulatory systems in the 1920s (Summers, 1998b; Bogossian, 1998a). Since this time, through the various Nurses Acts and regulations midwifery has remained 'invisible' in a legal sense in Australia (Barclay, 1985; Bogossian, 1998a). The public has no way, from a legal perspective to properly identify midwives or to determine what should be expected of their practice (Brodie and Barclay, 2001). This is of concern as currently, a number of maternity health care services and policy makers are seeking to maximise midwives' contributions through the development of new models of care that increase midwives' role in maternity care (NHMRC, 1998b; NHMRC, 1996; NSW Health Department, 1996; NSW Health Department, 2000b; Health Department of Western Australia, 2001; Pinch, Della, Margrie F, [Eds], 2001). At the same time, governments and health services are increasing the emphasis on consumers' participation in health service planning, provision, monitoring and evaluation (Commonwealth of Australia, 2001). If this eventuates a more knowledgeable and informed consumer will likely narrow the gap in knowledge that exists between the community and health professionals. There is evidence in one Australian study that this could lead to a concerted demand from consumers for greater choice (Zadoroznyj, 2000) and equity of access to maternity services, including primary care from midwives. There is current evidence of consumers taking this approach through the work of a coalition of consumers and midwives who are seeking access to primary midwifery services and greater recognition of the role of the midwife in Australia (Maternity Coalition, 2002).

The internationally recognised definition of a midwife states that:

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

(International Confederation of Midwives, 1990)

Australian governments, both State and Federal recognise this definition of the role of the midwife, consistently citing it in the policy and planning documents pertaining to maternity care as well as in several individual Nurses' Acts. See for example (NHMRC, 1996; NHMRC, 1998b; Victorian Department of Health, 1990; Shearman, 1989; NSW Health Department, 2000b; Nurses Registration Board of NSW, 1997; Nurses Board of Victoria, 1999).

Despite the recognition within policy documents, in Australia, as in most westernised countries midwifery's contribution has not been recognised or valued within what are mostly traditional models of care. Midwives have long been the assistant or 'handmaiden' (Leap and Hunter, 1993) to doctors who are seen by the majority of women as the experts in childbirth (Larkin, 1983; McGinley, Turnbull, Fyvie, Johnstone, MacLennan, 1995).

Recent Australian reports have recognised the changing role of the midwife and the need for midwives to develop their skills in relation to 'new models' of care in order to take responsibility and work to the full potential of their role (AMWAC, 1998; NHMRC, 1996; NHMRC, 1998b; AHWAC, 2002; NHMRC, 1998b; Kawachi, Kennedy, Lochner, Prothrow-Smith, 1997). In response to growing concerns about the Australian midwifery workforce and the educational systems that existed at this time, a national research project was developed to examine midwifery nationally. I was fortunate to be one of two full time researchers employed on the Australian Midwifery Action Project (AMAP).

2.7 THE AUSTRALIAN MIDWIFERY ACTION PROJECT

The Australian Midwifery Action Project was conceived at a particular time in Australian midwifery history and may later be seen as a watershed for these times. This is because of its comprehensive examination of the fundamental structures and systems that 'support' the practice of midwifery across Australia and the revelations that it has provided. The aim of the AMAP research was to provide evidence on which to base strategic planning for the profession, employers, workforce review,

educational reform, and policy direction in midwifery. AMAP also aimed to bring about improvements in the contribution midwives make to maternity care through facilitating and supporting institutional and systemic reform.

The AMAP project was conceptualised within two main 'strands'.

STRAND 1 consisted of a number of interrelated studies investigating state and territory differences in service provision, education, policy and regulation associated with midwifery care within maternity services.

STRAND 2 aimed to develop and test strategies for improving midwives' contribution to maternity care through facilitating and supporting institutional and systems reform.

The research team was led by Professor Lesley Barclay and consisted of two full time research midwives, myself and my colleague Sally Tracy and four associate researchers, Nicky Leap (initially from Flinders University, Adelaide), Karen Lane (Deakin University, Melbourne), Kerreen Reiger (La Trobe University, Melbourne) and Linda Saunders (Flinders University, Adelaide). The study took place in the period from early 1999 until mid 2002. The full report has been published and distributed widely (Barclay, Brodie, Lane, Leap, Reiger, Tracy, 2003) around the country. The main findings of the report included:

STRAND 1

- Workforce

The AMAP research identified serious concerns with current availability of registered midwives and a lack of any national coordinated approach or system of workforce planning (Tracy, Barclay, Brodie, 2000). One of the most alarming concerns revealed was the lack of comprehensive national data on midwives. Where data were available it demonstrated the shortage of midwives in each state, with rural and remote areas being particularly affected by short supply.

- Education

AMAP researchers cited concerns with the quality and lack of consistency in standards of educational programs offered leading to authorisation to practise midwifery. These concerns may explain in some way the lack of recognition of midwives' skills in Australia when compared to other western countries. The study identified low standards of Australian midwifery education, particularly when

international comparisons were made. These authors highlighted the need for major reform in the way midwifery education is organised and funded in Australia (Leap, 2002).

Researchers with the AMAP project collected data from the 27 universities providing midwifery education in Australia in order to present an overview of current educational programs. Problems such as the cost of postgraduate fees, no monitoring system to ensure consistent national standards of midwifery education and no adequate baseline of competence were all revealed during the study. Recommendations that ensure Australian midwives secure a more competitive position internationally will necessitate revision of the current programs for nurses wishing to become midwives and the introduction of comprehensive three-year undergraduate degree programs in midwifery - the Australian Bachelor of Midwifery (Leap, 2002). The introduction of the three-year Bachelor of Midwifery was cited as one issue that would highlight the need for reform in the regulation of midwifery in Australia. It also precipitated widespread debate about the needs of childbearing women, the community, maternity service providers, employers and governing authorities.

- Regulation

Analysis of the various acts and regulations affecting midwifery in Australia found serious inadequacies (Brodie and Barclay, 2001). The lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally, should raise concerns about the capacity of the current statutes to adequately protect the public and ensure that minimum professional standards are met. This analysis of the regulation was one my major contributions to the AMAP project and appears in the portfolio in Section One.

- Organisation of maternity care

The goal of integration of autonomous midwifery practice into mainstream maternity services though a collaborative approach was identified as a major challenge for service providers, policy makers, medical practitioners and midwives, in both urban and rural settings. During the term of the AMAP, I collaborated with another member of the AMAP research team Nicky Leap and our colleague Caroline Homer to produce a resource for midwives and managers to assist them in their efforts in setting up new models of midwifery care (Homer, Brodie, Leap, 2001).

- Rural and remote issues

Data from the AMAP study suggested that rural and remote midwifery may be in decline, with some midwives and employers concerned not only with the lack of availability of midwives, but also the potential loss of skills and expertise necessary to practise safely. Strategies for change in keeping with World Health Organisation recommendations, addressed the importance of Aboriginal health workers and midwives working in partnership as a key to reducing morbidity and mortality in Indigenous communities and providing care that is acceptable, appropriate and safe.

- Midwifery as a public health strategy

Research comparing the public health outcomes associated with methods of funding midwives in New Zealand and Australia and costing of the cascade of obstetric interventions for low risk women in childbirth in Australia were among some of the papers from the AMAP project (Barclay, Brodie, Lane, Leap, Reiger, Tracy, 2003). These have formed part of the second professional doctorate conducted during the term of AMAP and can be found in the completed doctoral thesis of Sally Tracy (Tracy, 2003).

STRAND 2

Identifying processes to strengthen midwifery and maternity care consisted of raising awareness and concern, providing evidence to enable informed decisions, influencing, activating and stimulating discussions at a range of different forums. Wherever the opportunity arose, the AMAP research team presented conference papers to midwives and employers and attended meetings with Commonwealth and State government health and education leaders. Meetings with key stakeholders such as employers, regulators, workforce planners, education providers, consumer groups, and health service managers, industrial bodies, professional groups and leaders (midwifery, nursing, obstetrics) were used to inform and educate about the issues. Approximately fifty of these meetings were held with in excess of ninety personnel. Over the three years of AMAP there were also numerous open forums with midwives to ascertain their views. These were utilised to conduct the 'Midwives voices' study' (Brodie, 2002), which appears in Section One of this portfolio.

2.8 LITERATURE REVIEW

A review of the literature regarding midwifery and continuity of care was conducted using the databases from MIDIRS (Midwives Information and Resource Service)

CINAHL (Cumulative Index of Nursing and Allied Health Literature) and CIAP (Clinical Information Access Program) and the Cochrane Index. This included a search for all randomised controlled trials and a substantial collection of non-randomised studies, qualitative research and reports. In addition, the researcher reviewed an extensive personal collection of proceedings from international, national and local conferences held since 1984.

2.8.1 The Benefits of Midwifery

One of the critical aspects in ensuring greater visibility and recognition of the role of the midwife is the demonstration of the benefits of midwifery care. The efficacy of midwifery as the central component of health care provided to women during pregnancy, childbirth and the postnatal period is well established (NHMRC, 1996; NHMRC, 1998b). Part of the internationally recognised definition of a midwife includes reference to the fact that the midwife:

“...must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.”

(International Confederation of Midwives, 1990)

Inherent in this definition is an assumption of autonomy that acknowledges midwives as practitioners in their own right, assuming responsibility, managing emergencies if they arise and referring and consulting as necessary. In Australia, by law, a qualified midwife is able to give total care to pregnant women and their babies throughout the antenatal, intra-partum and early postnatal period according to the international definition of a midwife's role and sphere of practice, as stated above. This means that midwives are qualified and accountable as practitioners in their own right. This contrasts with nurses who, particularly in their early years of initial practice work under the direction of a medical officer or senior nurse. Midwives recognise the benefits of multi-disciplinary collaboration and refer to other practitioners where necessary or appropriate but from the first day of registration are able to make clinical decisions and judgements in their own right.

In reviewing the evidence it appears that not only is midwifery efficacious, it has the potential to reduce morbidity without increasing mortality. A comprehensive population-based study of all births occurring in the USA compared differences in birth outcomes and survival rates for infants delivered by certified midwives or physicians. After controlling for medical and social risk factors this large national study concluded that care by certified nurse-midwives led to significantly better neonatal mortality and morbidity rates and higher mean birth weights compared to physician led care (MacDorman and Singh, 1998).

The largest published study regarding midwifery-led care is the National Birth Centre Study, conducted in the USA with 84 freestanding birthing units involving 12,000 women (Rooks, Weatherby, Ernst, Stapleton, Rosen, Rosenfield, 1992). This study was a prospective observational survey of antenatal, intrapartum and postnatal care with a large sample size adding strength to the findings. A smaller prospective study of 2000 matched women at low obstetric risk who gave birth in standard maternity hospitals further supported the results of the observational study. Women who had their babies at the birth centres had fewer labour interventions eg. analgesia, inductions or continuous fetal monitoring. Mortality and morbidity rates were no different to those in conventional hospital care. Additionally, birth centres were cheaper and attracted a lower socio-economic group who could not afford standard maternity care provision (Rooks, Weatherby, Ernst, Stapleton, Rosen, Rosenfield, 1992).

A retrospective study in Germany compared births from freestanding midwifery-led birth centres with hospital births in matched groups of women. This study demonstrated that birth centre care was associated with significantly fewer medical interventions and a similar perinatal mortality rate (David, von Schwarzenfeld, Dimer, Kentenich, 1999). These authors concluded that if risk selection was thorough, there was no evidence of increased maternal or perinatal risk associated with 'midwifery led' care in these types of birth centres. However, as Walsh (2000) points out, care should be taken regarding generalisability in a study that adopted one of the weakest comparative designs (Walsh, 2000).

Despite the presupposition by most of contemporary western society that the acute hospital setting with access to emergency equipment and personnel is the safest place to give birth, there is little evidence to support such a belief. Researchers in the UK in fact concluded that for a healthy woman with a normal pregnancy (including women having their first baby), a planned home birth with care from a

qualified midwife is as safe as a hospital birth (Campbell and Macfarlane, 1994). In Britain, supported by growing evidence of their benefits (Rooks, Weatherby, Ernst, Stapleton, Rosen, Rosenfield, 1992), there are calls to resist the trend to establishing 'mega-maternity' units. This is occurring alongside a growing movement to encourage the expansion of freestanding 'midwifery led' birth centres (Walsh, 2000; Kirkham, 2003)

In Sweden, a ten-year retrospective study showed a statistically higher rate of perinatal mortality in primigravid women who received care from midwives in birth centres (Gottvall et al, 2004). This study used a specialist obstetrician as the expert assessor to examine preventable factors in a number of the cases of perinatal deaths in the birth centre group. The use of an obstetrician to examine outcomes of midwifery care leaves the findings open to criticisms of bias associated with a lack of balance of professional opinion. The review suffers from lack of input from expert midwives to ensure any underlying philosophical beliefs could be offset.

Two Cochrane reviews relating to midwifery led care noted in their discussion the trend towards a higher level of stillbirth / neonatal deaths in the midwife led care arms (Hodnett, 2004a; Hodnett 2004b). One prominent midwifery leader in England has challenged the basis upon which these conclusions have been made (Walsh, 2004). Walsh argues that authors at some of the sites had previously concluded that the deaths were not preventable (MacVicar et al, 1993). In at least one case, the death occurred some time after transfer out of midwifery care with the care provided after transfer reported by the reviewer as being 'sub-optimal'. Also, retrospective or hindsight bias (Zain et al, 1998) is a well known phenomena which has led some researchers to use a blinded method so that reviewers are not aware of outcomes prior to conducting their assessment.

The inferences made by the Cochrane review of continuity of caregivers (Hodnett, 2004a) can be questioned further when it is noted that these reviewers omitted the largest randomised controlled trial about team midwifery care (Homer et al 2001). As discussed previously this study of 1089 women found significant benefits associated with midwifery led care including a significant reduction in caesarean section rates from 17 % to 13% (Homer et al 2001) with no increase in adverse outcomes for women or babies. Addition of this large study to the next review by Cochrane might move the 'trend in the pattern of data' away from the one that currently seeks to question the safety of midwife led care.

These concerns and suggested possible trends in the pattern of data are worthy of exploration. Interestingly, the Cochrane reviewers concluded that 'since there is no theoretical basis for suggesting that continuity of care by a team of caregivers could be harmful, the problem, if there is one, may lie in the management of high risk pregnancy by midwives, even when a good referral system is in place' (Hodnett, 2004). Within the international literature, there has also been discussion about the appropriate level of involvement of specialist obstetricians in the care of women anticipating normal childbirth. A consortium of obstetric and perinatal experts concluded that 'the routine involvement of doctors in the care of all women during pregnancy and childbirth is unlikely to be beneficial' (Hodnett, 2004a).

These findings are significant in terms of the impact they [arguably] should have when considering the planning, development and organisation of future maternity services. This is discussed more fully later in the thesis. They also point to the need for ongoing research that addresses more specifically the 'processes' of care, in particular the 'transitions' in care that occur when women require transfer from midwifery into secondary or tertiary care. The factors associated with perinatal morbidity and mortality requires closer scrutiny from a multi-disciplinary group of experts in that particular form of care. There is a need for new research that looks at the experiences of the different care providers including the communication and networking patterns that enhance and restrict collaboration and team working.

2.8.2 Continuity of Midwifery Care

Continuity of care is a term that is used widely in contemporary maternity services. It is often confused with the concept of continuity of carer, which refers to care, by a midwife whom the woman has previously met, feels that she has a 'relationship' with and considers she 'knows'. In contrast, continuity of care refers to a consistent philosophy, or organisational structure underpinning the care provided. For example, a team of six midwives may provide continuity of care, although the woman may not 'know' or have a continuing relationship with each individual midwife (Homer, Brodie, Leap, 2001). Models of continuity of midwifery care often fall into one of two general categories, that is, caseload practice or team midwifery. They may be provided from a variety of settings, for example, in a community health centre, a hospital clinic or a freestanding or integrated birth centre. These models of maternity care can cater for privately insured or non-insured women. While risk is often used as a criterion, some models cater for healthy women, whilst some are specifically

developed for women with recognised risk associated pregnancies and others accept women of all risk and work closely with the medical team.

Research into systems of maternity care that provide continuity of midwifery care suggests that there are positive benefits for women and for health systems. Continuity of midwifery care has been shown to reduce interventions in labour, particularly augmentation of labour, use of analgesia and electronic fetal monitoring (Flint, Poulengeris, Grant, 1989; Kenny, Brodie, Eckermann, Hall, 1994; Rowley, Hensley, Brinsmead, Włodarczyk, 1995; Waldenström, Nilsson, Winbladh, 1997). An Australian randomised controlled trial of 1089 women (Homer, Davis, Brodie, et al, 2001) and a Canadian trial of 200 women (Harvey, Jarrell, Brant, et al, 1996) have both demonstrated a significant reduction in caesarean section rate associated with continuity of midwifery care. Women in the trial by Homer et al (2001) were selected from a broad population of women with a variety of risk factors. These women were able to continue with the midwifery-led model of care even if pregnancy-related complications developed because the midwives referred and collaborated closely with obstetric care providers.

Another Australian trial also reported a trend towards a reduced elective caesarean section rate in high-risk women (Rowley, Hensley, Brinsmead, Włodarczyk, 1995). A retrospective cohort study in California has also shown that supportive nurse-midwifery care in labour was associated with a reduced caesarean section rate (Butler, Abrams, Parker, Roberts, Laros, 1993). Oakley, in the UK, also showed increased birth weight in infants of 'high risk' mothers who received continuity of midwife care (Oakley, Rajan L, Grant, 1990; Oakley, Hickey, Rajan L, Grant, 1996).

Continuity of midwifery care has been shown to improve women's experiences with care during pregnancy and childbirth (Rowley, Hensley, Brinsmead, Włodarczyk, 1995; Waldenström and Nilsson, 1993; Flint, Poulengeris, Grant, 1989; Homer, Davis, Brodie, 2000; Kenny, Brodie, Eckermann, Hall, 1994; MacVicar, Dobbie, Owen-Johnstone, Jagger, Hopkins, Kennedy, 1993). In particular, women who have received continuity of midwifery care reported greater preparedness for birth and early parenting (Flint, Poulengeris, Grant, 1989; McCourt, Page, Hewison, 1998), increased satisfaction with psychological aspects of care (Waldenström and Nilsson, 1993) and higher participation in decision making (Turnbull, Holmes, Shields, et al, 1996) than women who received standard care.

Much of the literature reporting the benefits of continuity of midwifery care has not explicitly determined the degree to which within the various models, women get to

know their midwife. Indeed there is an ongoing debate in the UK as to which aspects of the model of care make a difference to women's experiences (Green, Curtis, Price, Renfrew, 1998). Whilst there is evidence that demonstrates improvements in outcomes associated with continuity of midwifery care, just which aspects of the care are important to women who achieve these improved outcomes is less clear (Green, Renfrew, Curtis, 2000). As Page (2000) points out more qualitative research is required in order to determine the links between continuity of carer and specific outcomes, including what is important to women themselves (Page, 2000). Nonetheless, it is self-evident that in addition to skilled and compassionate care, the opportunity to develop a relationship that may increase the level of trust (Brodie, 1996a) between the woman and the midwife during the experiences of labour and giving birth would be welcomed by most women.

In an ethnographic study with women who had received both birth centre and traditional maternity care, care from midwives within the birth centre was described as 'humanistic and woman-empowering' (Esposito, 1999). In describing midwifery care, women identified key issues as control of the birth environment, the opportunity to develop supportive interpersonal relationships with midwives, to have a safe birth and to be treated with dignity and respect – all of which were less evident within the hospital system (Esposito, 1999).

Continuity of midwifery care has also been associated with reduced costs to the health system in three Australian randomised controlled studies (Rowley, Hensley, Brinsmead, Wlodarczyk, 1995; Kenny, Brodie, Eckermann, Hall, 1994; Homer, Matha, Jordan, Wills, Davis, 2001).

Benefits to midwives in association with providing continuity of care have also been shown. In Britain, Sandall (1997) demonstrated greater job satisfaction and less burnout associated with occupational autonomy for midwives providing continuity of care within midwifery 'caseload' models (Sandall, 1997). More recently Ball and colleagues revealed 'dissatisfaction with midwifery roles' as a major reason for midwives leaving the workforce in the UK (Ball, Curtis, Kirkham, 2002). This comprehensive study involving 2325 midwives cited contradictions between what midwives were taught in their education and the reality of the practice domain, quoting many respondents as having

“An unwillingness to continue to practice the type of midwifery that is demanded of them in the modern NHS”

(Ball, Curtis, Kirkham, p 82, 2002)

In Australia, links between increased job satisfaction, expanded roles and greater emphasis on models of care that increase autonomy have also been found and identified as important to midwives in their career development and willingness to remain in the profession (Watson, Potter, Donaghue, 1999).

Consequently, in 2002 in Australia growing evidence of the benefits of smaller ‘midwifery led’ freestanding birth centres to women and to midwives (Walsh, 2000) (Rooks, Weatherby, Ernst, Stapleton, Rosen, Rosenfield, 1992; Campbell and Macfarlane, 1994; Hodnett, 2004b) is contributing to calls from consumers for access to midwifery models of care (Maternity Coalition, 2002)

Evidence that supports the expansion of midwifery care is demonstrated throughout Australian policy and planning documentation pertaining to maternity services (NHMRC, 1996; NHMRC, 1998b; Commonwealth Department of Health and Aged Care, 1999; NSW Health Department, 2000b; South Australian Health Commission, 1995; Department of Human Services, 1999). The potential for this evidence and policy direction to influence a reorganisation of service provision to improve the efficiency and quality of Australian maternity services through an increase in the utilisation and recognition of the midwife’s role, appears self-evident. However, actual evidence of any widespread change and reorganisation in service provision, apart from several individual locally-based innovations, appears to be lacking.

2.9 RATIONALE FOR INCREASING THE STATUS OF MIDWIFERY

As presented above, there is a growing body of evidence to suggest that continuity of care by midwives significantly improves outcomes by reducing the need for medical interventions. Women’s satisfaction with care is significantly higher and cost efficiency gains related to reduced medical interventions are also associated with midwifery models of care (Homer, Matha, Jordan, Wills, Davis, 2001; Tracy and Tracy, 2003).

Midwife led care is based on the premise that women benefit by receiving care from a midwife with whom they are able to form a relationship. The social support and reassurance offered by the establishment of a trusting relationship with the midwife is believed to reduce anxiety and increase confidence. The mother is then more

likely to have an improved outcome and to experience greater satisfaction with her care (See for example: (Flint, Poulengeris, Grant, 1989; Klaus, Kennell, Robertson, Sosa, 1986; Oakley, Rajan, Grant, 1990; Oakley, Hickey, Rajan, Grant, 1996).

Internationally, increased costs, women's declining satisfaction with maternity services and considerably increased morbidity attached to intervention rates, are forcing a 'rethink' of the traditional medically dominated systems of birthing (Laslett, Brown, Lumley, 1997; Kaufmann, 2000; Hodnett, 2004a; World Health Organisation, 1996; Rosser, 1998; Grant, 2000). As previously discussed, in Australia within a context of increasing evidence of the effectiveness of midwifery, several government reports and inquiries have recommended changes and reorientation of maternity services. Greater recognition and utilisation of midwifery skills associated with a redirection of maternity services towards a primary health oriented community based system of care are common features of these reports (Health Department of Western Australia, 2001; NSW Health Department, 1989; Victorian Department of Health, 1990; South Australian Health Commission, 1995; Commonwealth Department of Health and Aged Care, 1999; NSW Health Department, 2000b). Of perhaps greater importance, and within the context of evidence rather than political strategy or specific health policy, the work of two National Health and Medical Research Council (NHMRC) committees have confirmed the safety and benefits of midwifery care for healthy women (NHMRC, 1996; NHMRC, 1998b). Many of these reports identified reforms that should occur within a framework of evidence based approaches to the development of new models of care that are based on 'best practice' maternity care and represent a structured approach to comprehensive antenatal, postnatal and early childhood health services. These models will incorporate a population-based primary health care approach aimed at improving both the mental and physical health of mothers, their infants and families (NSW Health Department, 2000b). Greater visibility and utilisation of midwives is a central component of the reforms that will be necessary to enable the various models of public health sector care to develop (Esposito, 1999; Walsh and Newburn, 2002).

2.10 SUMMARY

This section has outlined the evidence for the introduction of models and systems of maternity care that increase the utilisation of midwives. The international, national and local health policy and strategic directions in maternity services have also been presented.

Innovative models of maternity care are being piloted and implemented in some areas across Australia. However, it is not possible to determine the exact scope of these innovations many of which remain unpublished and only reported anecdotally. The anecdotal evidence suggests that such developments are not common, particularly in rural and remote areas. Clearly there exist a number of barriers to the widespread introduction of new models of maternity care in Australia.

Despite the significant amount of evidence that continues to accumulate to support the expansion of midwifery models of care, such changes for the most part have not taken place apart from a small number of innovations. It appears that part of the problem is in fact, barriers to recognising and acknowledging midwifery itself.

The reasons why this situation continues to exist despite recommendations for change will form the basis for this portfolio. Midwives have continued to remain invisible and not recognised as primary carers in their own right, despite a sound rationale for this.

This proposition is tested later in the portfolio in Section Two.

The portfolio assumes and tests the notion that leadership is a potential strategy that is required to build professional capital and increase the recognition and visibility of midwives. The need for improved leadership and collaboration as well as concerns about the quality of maternity care and midwives' visibility and capacity to contribute will be identified and examined.

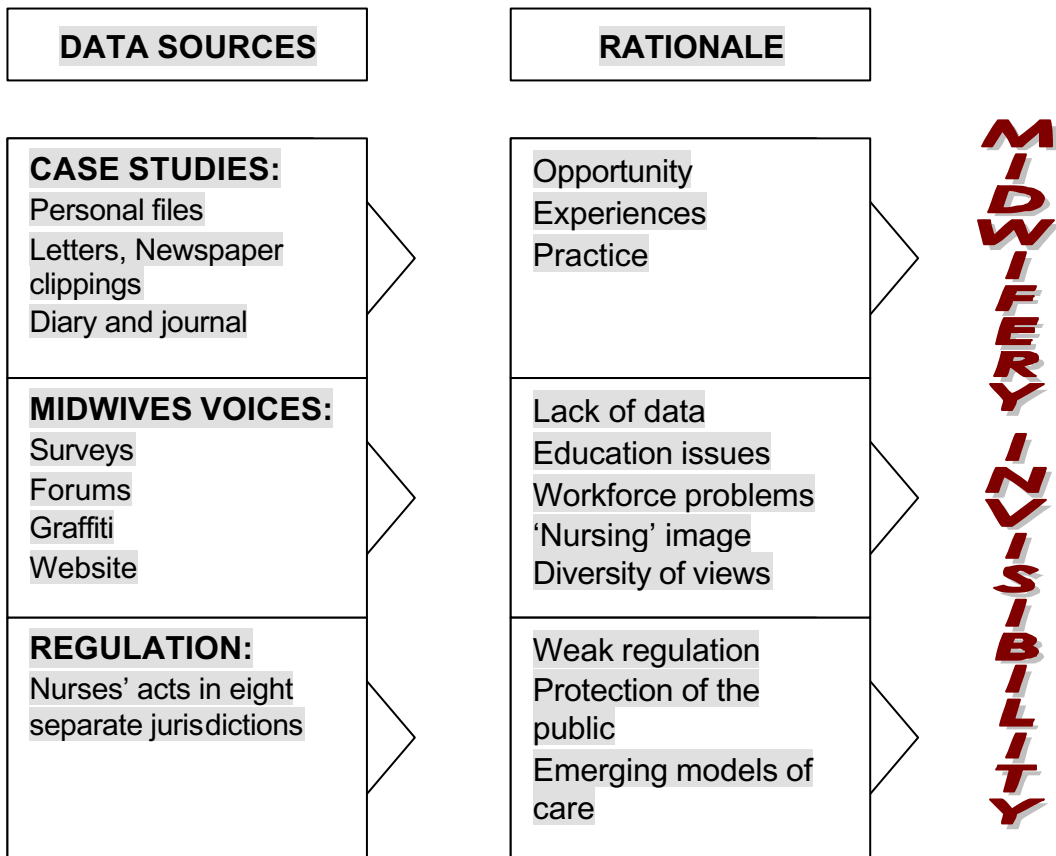
In the next section, the problem of invisibility of midwifery in maternity care will be identified through the three separate case studies and two empirical studies. Each of these will seek to explore the barriers to midwifery and analyse the reasons why, despite strong evidence, consumer demand, government policy and reported positive experiences from other western countries, Australian women have not had the benefit of improved models of care and choice of access to care from midwives.

The strategy that I have chosen is to reflect on my own practice and experiences gained through the collation of personal reflections and stories, as described in the three case studies. The data for the case studies comes from the identification of issues and assumptions that I have made about leadership and the invisibility of midwifery. These assumptions are then tested through the conduct of two empirical studies – the 'Midwives' Voices' study and the 'Midwifery Regulation' study.

The findings of these studies confirm the problem of the invisibility of midwifery in Australia. They also highlight major concerns with the lack of cohesive leadership that could assist in addressing the significant problems identified.

The analysis of the findings enabled theorising and extrapolating about the problems, which led to the development of some potential solutions.

This process can be explained diagrammatically as follows:



3.0 SECTION ONE - CONFIRMING THE PROBLEM

This section presents three separate pieces of empirical research. These were developed to test the proposition of the invisibility of midwives and midwifery within Australian maternity care. These studies were firstly, a study of perceived barriers to midwifery within mainstream maternity services, in which I sought the views of a cross-section of Australian midwives. Secondly, I conducted an analysis of the eight different Nurses' Acts in Australia and reviewed the regulation of midwifery, identifying issues affecting the practice and education of midwives. The third study reports a series of three case studies of midwifery leadership, which involved attempts at developing or improving models of maternity service provision by increasing the contributions that midwives could potentially make. Here I analyse direct involvement in leadership activities that took place across three different contexts: practice change, health service organisational development change and attempts at state-wide maternity care policy reform.

3.1 STUDY ONE – THE MIDWIVES' VOICES

3.1.1 Context

In recent years the profession of midwifery in Australia has undergone considerable change. Since 1990 there has been a continuing decline in the actual numbers of midwives educated and by 2002 concerns were being raised about the quality of midwifery education and practice (Tracy, Barclay, Brodie, 2000; Leap and Barclay, 2002). The Australian Midwifery Action Project (AMAP) came about because of an increasing level of concern put forward by some midwifery leaders, who identified problems with standards of education, midwifery practice and the limited range of midwifery services available to women. There was a growing consensus that Australian midwifery was in rapid decline and falling behind international standards.

This study was designed to give a voice to a cross-section of midwives, the majority of whom were currently practising and thus arguably, were in the best position to identify, through experience, the existing barriers to their role and practice.

3.1.2 Literature Review

Considerable research has been conducted to examine the experiences of midwives involved in 'midwifery led' models of care (Brodie, 1996b; Green, Coupland, Kitzinger, 1988; Sandall, 1997; Stevens and McCourt, 2002; Brodie, 1996a; Stevens and McCourt, 2002a) or in the reorganisation of traditional maternity services

(Sikorski, Clement, Wilson, Das, Smeeton, 1995). Little is known however of the views of midwives with regard to their experiences in the current organisation of mainstream Australian maternity services and the prevailing 'systems' and standards of midwifery practice.

In the United Kingdom, several authors explored the likely impact of health service policy change and reform on the role of the midwife (Bennett, Blundell, Malpass, Lavender, 2001; Lavender, Bennett, Blundell, Malpass, 2001). These studies focused on midwives' responses to proposed changes to, and extensions of, their role, as part of a broader National Health Service (NHS) initiative to develop a more flexible health workforce (Department of Health UK, 1997). Whilst welcoming changes that may improve services to women, midwives in the study highlighted concerns about additional workloads and the need for ongoing education to enable them to adapt to the proposed new roles (Pope and et al, 1996). It is likely that similar experiences would be reported in Australia if the role of the midwife was to be extended.

Kirkham and Stapleton (1999) examined the culture of midwifery within the NHS in the late 1990s across England. Their research highlighted contradictions in practice whereby midwives were expected to support and 'be with' women as clients but were unable to acknowledge their own need for support and recognition. The voices of contemporary English midwives were described as being 'muted'. Midwives appeared to have assumed a professional state of 'learned helplessness and guilt' (Kirkham and Stapleton, 1999b p744). It was my experience and view at the outset of developing this study that the current state of Australian midwifery may be in a similar condition due to different, but related causes.

In Australia, researchers from within the midwifery profession have in the last five to ten years, questioned inconsistencies and apparent failures of the regulatory and education systems in place for midwives (Summers, 1998a; Tracy, Barclay, Brodie, 2000; Waldenström, 1996; Tracy, Barclay, Brodie, 2000; Summers, 1998b). This followed similar concerns originally identified more than fifteen years earlier (Barclay, 1984; Bogossian, 1998b) that were never formally addressed (Barclay, 1995). These matters may have been exacerbated by the move from hospital-based midwifery education to the tertiary sector in the late 1980s and early 1990s. From my experience in practice at the time of this study, it was anticipated by many midwives that a tertiary-based education would bring distinct opportunities for educational and academic advancement alongside a similar process that had been

achieved for nursing. The move for nurses was recently heralded as a significant success (Department of Education and Department of Health and Ageing, 2002). Noticeably, a similar move for midwives has never been the subject of formal evaluation to determine its impact on the standards of midwifery care and practice.

In this context, I was of the view that midwives themselves may have some important insights to offer to the AMAP research. Given the evidence to support a greater role for midwives and the growing status of midwives in other countries, it was important that the 'barriers' to midwifery, as perceived by midwives themselves were explored and analysed.

3.1.3 The Midwives' Voices Study

The following paper is the result of a study that I designed as part of AMAP to give a 'voice' to Australian midwives. This was an opportunity to identify the barriers to their role and practice in mainstream maternity service provision, within a context of increasing demands for, and expectations of, the role of the midwife in Australia. As part of the study, midwives were asked to respond to two key questions drawn from the larger AMAP research. These were:

- What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia?
- What are the strategies to overcome these barriers?

The choice of method for data collection proved quite challenging and is worthy of some elaboration. The AMAP research team knew that it was important to gain the views of as many midwives as possible and also to seek a representative sample from a broad cross-section. After some lively and creative discussion within the team the concept of 'graffiti' method was invented as an innovative approach to the collection of views, opinions and ideas from midwives from all parts of the country. Access to midwives' views was made possible through the researchers' attendance at multiple different sessions where participants could contribute in their own way, through the use of interactive forums, surveys, the 'graffiti board'. The 'graffiti' approach was also available on a website designed especially for the purpose of the study. A more in-depth explanation and theoretical construction of the 'graffiti' method can be found in [my AMAP colleague] Sally Tracy's recently completed professional doctorate (Tracy, 2003).

The 'interactive forums' were not focus groups but interactive discussions, included as part of twenty-eight different educational programs attended by midwives. These took place in every capital city and several rural / regional centres throughout Australia in 1999 and 2000. More than 5000 midwives attended these educational programs and an estimated 75% actively participated in the forums. They aimed to develop both individual and consensus views on the two research questions.

'Graffiti' boards were also used at the completion of the interactive forums. These were large sheets of white paper that were placed around the walls of the venue. Participants were encouraged to make additional comments on these after the session had concluded. The 'graffiti' board provided an opportunity for anonymity in the way raising a point within the forum could not. The purpose of the 'graffiti' boards was to allow those who may not be comfortable responding in a discussion group to 'have a say' (Tracy, 2003). This allowed those who had ideas contrary to the larger group, to present them and to identify issues that midwives were particularly concerned about which did not get discussed fully in the interactive forum.

A third component of data collection was circulation of the individual 'graffiti' sheet. This was distributed through the journals (see Table 1) that most midwives across Australia receive through membership to their professional or industrial organisations (The Australian Nursing Federation [ANF] and its branches) and the Australian College of Midwives (ACMI). Nursing journals were used to distribute the 'graffiti' sheet because many midwives are not members of the ACMI but are members of nursing industrial organisations for legal, insurance and other reasons. Dissemination through these journals allowed for a very wide distribution and opportunity for contribution. A total of 129,226 'graffiti sheets' were posted in the journals to members of these organisations. Three thousand two hundred 'graffiti' sheets were also sent specifically to midwives who were members of the ACMI, through the 'Journal of the Australian College of Midwives'.

Table 1: List of the journals and publications that were utilised for the distribution of the ‘graffiti sheet’⁴.

Australian Nursing Journal
Journal of the Australian College of Midwives
The Lamp – Newsletter of the NSW Nurses Association
The Queensland Nurses Journal

The ‘graffiti’ sheets were anonymous. Participants could not be identified in any way, with name or designation not required (Appendix A). The ‘graffiti’ sheet survey increased the level of anonymity compared to the ‘graffiti’ board and interactive forums and provided access to midwives who had not attended the conferences and seminars.

A fourth component was the generation of responses to the research questions through an electronic ‘graffiti sheet’. This was provided on the website of the Centre for Family Health and Midwifery, University of Technology, Sydney. The web-based survey was advertised through conferences, seminars and journals and by word of mouth using hospital managers from the member hospitals of the organisation ‘Women’s and Children’s Hospitals Australasia’.

This method, and the perceived inclusive approach, proved popular with the midwives with many positive comments being scribbled on the corners of ‘graffiti’ sheets or surveys. For example:

“thanks for letting us have a say” ... “we need more opportunities like this” ... “thank you to the AMAP team for listening to our concerns”.

(SYD9)

These gestures from the midwives led me to believe that they required a more prominent and ongoing platform for their voices to be heard. The experience of conducting the study and analysing the many thousands of responses gathered, highlighted the perception that midwives have of themselves and what they believe others have of them.

⁴ See Appendix A

In particular, midwives expressed concerns that midwifery autonomy was not recognised or supported. This was contributing to lack of job satisfaction and increasing attrition from the midwifery workforce, which has also been found in Britain (Stafford, 2001). Many respondents reported lack of support and recognition from nursing managers and health service leaders. They linked this to a perception that midwives' professional identity and image were confused with nursing. They highlighted the need to recognise the difference between the work of midwives and nurses. Managers and service leaders identifying midwifery work within the nursing culture was a key strategy to midwives being able to contribute effectively to safe and effective maternity services.

The published paper reports on an analysis of the concerns and barriers that midwives identified (Brodie, 2002). For the purposes of the rest of the portfolio I draw from these midwives' voices a significant degree of despair and hopelessness. This despair related to their perceived lack of recognition and status about which they seemed at a loss to know what to do. The overall status and lack of visibility of midwifery within society, and in the health system, was identified as a major barrier to their ability to make a significant contribution, or indeed to be heard at any level.

Strategies identified to address the lack of recognition and visibility included the need for those in authority to show leadership and advocate for increased recognition of midwifery within the health system and the wider community. From this I further extrapolated ideas on the need for leadership as strategy to assist in the development of professional capital.

The completed paper reporting on the study was published in the Australian College of Midwives Journal in September 2002 and is reproduced in the following pages. The results were also shared with midwives and others participating in several different conferences and educational forums through presentations given from late 2001 and throughout 2002. These are listed in Appendix H.

Participants in the 'Midwives Voices Study' have highlighted the need for review and reorganisation of midwifery services within mainstream maternity care provision. Their responses indicate that the profession of midwifery in Australia is in crisis.

3.1.4 The Midwives' Voices Publication

Brodie PM. Addressing the Barriers to Midwifery - Australian midwives speaking out. Journal of the Australian College of Midwives (2002) Vol 15 No 3 pp 5-14.



ADDRESSING THE BARRIERS TO MIDWIFERY - AUSTRALIAN MIDWIVES SPEAKING OUT

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ABSTRACT

This research gives a voice to midwives in identifying the barriers and current problems in the organisation of maternity care in Australia. Using a critical feminist research approach, data was collected from a cross section of midwives nationally. Through standard qualitative research methods, themes were identified that enabled analysis of significant issues affecting the current status of midwifery.

The system of maternity care was identified as being dominated by medicine, not evidence based and restricting of women's choices, with midwifery autonomy not recognised or supported. The invisibility of midwifery within the community was identified as a significant barrier which, in conjunction with the occupational imperialism of obstetrics, ensures ongoing strategic control of maternity services and a denial of the rights of consumers to access midwifery care.

INTRODUCTION

This study as part of a larger project¹ explores and reports the views of midwives from across Australia in identifying the barriers to midwifery within mainstream maternity service provision.

CONTEXT AND LITERATURE REVIEW

In Australia, there are approximately 250,000 live births annually (Nassar and Sullivan, 2001). The majority of these births take place in hospitals staffed by approximately 13,800 registered midwives and nurses working in midwifery (AIHW, 2002), with medical care available either 'on call' or 'on site'. High standards of maternity care are based on the assumption that there is, and will be, the availability of qualified midwives for all women during labour, birth and the postnatal period. Whilst there are clearly areas requiring significant improvement, particularly with regard to Indigenous perinatal outcomes, childbirth in Australia is considered

relatively safe compared to international standards, with a fetal death rate of 6.7 per 1,000 live births (Nassar and Sullivan, 2001).

Research investigating systems of maternity care suggests that there are positive benefits for women and health systems associated with the increased utilisation of midwives' skills (Waldenström and Nilsson, 1993) Rowley et al. 1995; (Homer et al. 2000; MacVicar et al. 1993; Flint et al. 1989). An Australian trial of 1089 women (Homer et al. 2001a) and a Canadian trial of 200 women (Harvey et al. 1996) both demonstrated that continuity of midwifery care can lead to a significant reduction in caesarean section rates. In Britain, supported by increasing evidence of their benefits (Rooks et al. 1989; Campbell and Macfarlane, 1994; Hodnett, 2001), there is a growing movement towards the expansion of midwifery led, free standing birth centres (Walsh, 2000). Continuity of midwifery care has also been associated with reduced costs to the health system in three Australian studies (Rowley et al. 1995; Kenny et al. 1994; Homer et al. 2001b).

The potential to reorganise and improve the efficiency of Australian maternity services through an increase in the utilisation and recognition of the midwife's role is demonstrated through research, policy and planning documentation (NHMRC, 1996; NHMRC, 1998). However, actual evidence of widespread change and reorganisation in service provision is much less evident. The AMAP study sought to provide evidence on which to base strategic planning and to bring about improvements in midwives' contribution to maternity care through facilitating and supporting institutional and systemic reform. Within this context the views of midwives were sought to answer two research questions:

1. What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia?
2. What are the strategies to overcome these barriers?

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. This included workforce, regulation, education, and practice and service delivery issues across the country.

METHOD

Sample and data collection

Multiple data collection methods were used over a two-year period. Interactive forums with groups of midwives participating in 28 separate professional conferences and seminars as well as the use of 'graffiti' boards, anonymous surveys or 'graffiti' sheets (sample 'graffiti sheet' survey is available on request from the author) placed in professional journals (Table 1) and on a website, were all utilised. Five hundred and sixty three responses were received, with three hundred and ninety six respondents (73.3%) stating that they were registered midwives in current practice. Geographic spread of respondents was extensive with sixty-eight responses (28.8%) from participants with postcodes identified as coming from either remote or rural regions.

TABLE 1

Table 1: Journals and publications that were utilised for the distribution of the 'graffiti sheet'.

Australian Nursing Journal
Journal of the Australian College of Midwives
The Lamp - Newsletter of the NSW Nurses Association
The Queensland Nurses Journal

Data analysis

Using the NUD.IST software program, data was analysed for thematic content (Strauss A & Corbin J, 1990) and ascribed labels identified as 'nodes'. Attaching nodes to the data enabled the researcher to conceptualise and arrange observations, words and responses into themes that allowed for further analysis and interpretation (Strauss A & Corbin J, 1990). As an example, Figure 1 demonstrates the 'parent' node for the theme 'midwifery practice' and the five 'child' nodes that relate to it. Thus the 'parent' node 'midwifery practice' represents the linkage of a number of themes that arose in the data from the sub group of 'child' nodes.

RESULTS

A clear picture of the challenges facing Australian midwifery practice has emerged from the midwives' data. Respondents described their role and practice as being constrained by several factors. These factors have been grouped around several sub-sets of themes related to service provision and the practice domain of midwives. These were then assembled as a map to visually demonstrate the complexity of barriers to practice as well as the broader service provision environment that participants described (Figure 2- page 6).

Throughout the reporting of the results, key issues and strategies are illustrated through the use of quotes. These are then incorporated and reflected in the analysis and discussion.

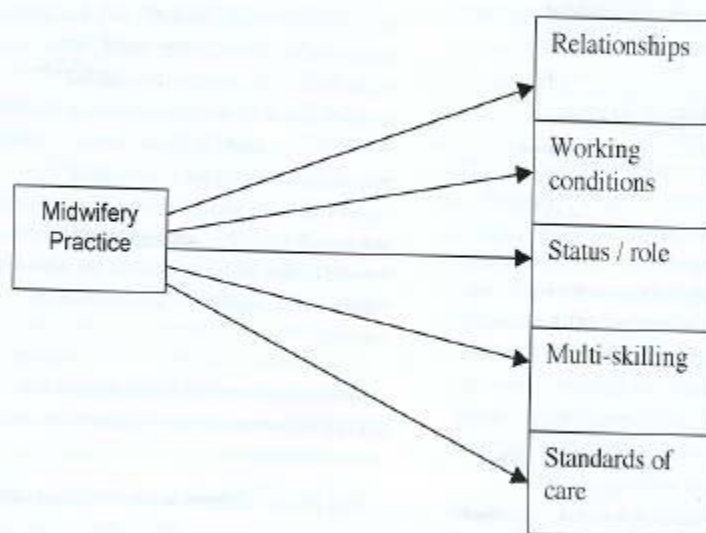


Figure 1: Coding of the relationship of the 'midwifery practice' 'parent' node to related 'child' nodes

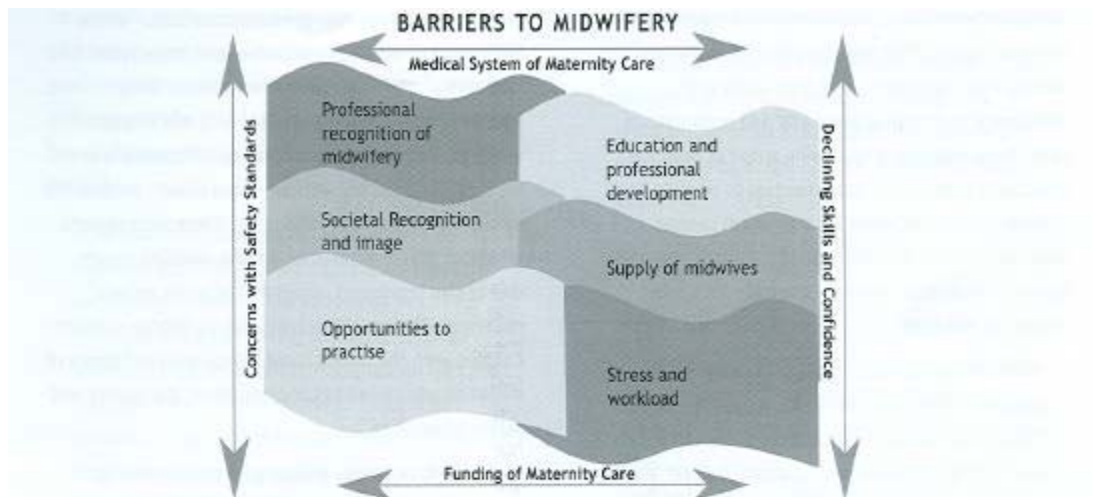


Figure 2. Complexity of barriers to Australian midwifery

KEY THEMES EMERGING FROM THE ANALYSIS

Professional recognition

Reports of lack of professional recognition of midwifery and the role of the midwife came equally strongly from midwives in urban and rural settings. The philosophy of care, whether the workplace culture was medically focussed or woman-centred³, played a part. Models of medically dominated practice were not the exclusive domain of medical practitioners, with reports that some midwives and unit managers also supported a 'medical' approach to care. For some, this was perceived to occur because of a lack of recognition of the benefits of midwifery and the high level of nursing and medical dominance of midwifery practice that restricted midwives' desire to fulfil their role.

"We need to overcome the medical ownership of maternity care and this will not only involve focusing on doctors, but also on challenging the practice of many current midwives who rely on the security blanket of 'medicalisation' " (AL 2)

"There are times when it feels like two teams working from different paths - women centred vs medical controlled care - all aiming for the women to have a safe birth but not really believing in each other's methods or supporting each other's practices." (DA 1)

In some areas, midwives described an urgent need for role models or more skilled midwifery leaders. This need was exacerbated by an overt focus on 'nursing' in matters of professional education, management and organisational leadership.

"It's a medical model of care which is perpetuated by the nursing profession as well. We need stronger recognition of midwifery as a separate profession from nursing. (AS5)

A perceived resistance to change, such as reluctance to develop midwifery models of care and evidence based practice, was reported. Whilst there were several notable exceptions, resistance to both change and the embracing of midwifery models of care was a recurrent theme that emerged from the analysis.

"Many of the midwives here have never professionally updated themselves and they are essentially barriers to women's choices." (AD 2)

Opportunities to practise

Opportunities to practise across the spectrum of maternity care varied according to how services were organised and the prevailing philosophy of care. For example a 'medical' model of care, where general practitioner obstetricians provided all antenatal care and had responsibility for intra-partum care, resulted in midwives not having access to antenatal practice as

³ In midwifery, 'woman-centred' is a concept that implies the following: Midwifery focuses on a woman's individual, unique needs, expectations and aspirations, within the recognition of her particular social milieu, rather than the needs of the institutions or the professions involved. Implicit is the notion that 'woman-centred' encompasses the needs of the baby, and the woman's family, her significant others and community, as identified and negotiated by the woman herself. Midwifery recognises the woman's right to self-determination in terms of choice, control and continuity of care from a known or known caregivers. Midwifery follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary. Midwifery is 'holistic' in terms of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations (Australian College of Midwives Inc., 2002)

well as experiencing a reduction in their autonomy in decision making. This had the effect of midwives feeling that they were losing their skills and confidence in providing antenatal and intra-partum care. Many reported a narrowing scope of practice associated with lack of opportunities to provide basic midwifery care. Midwives in large urban centres reported systems that segregated care into antenatal, labour or postnatal care with the midwife's role limited to one area.

"We don't get an opportunity to work in all spheres of midwifery for which we are qualified. There is no ability to practice in the community due to lack of government financial support and the medical dominance of all aspects of maternity care. There is a real lack of autonomy in midwifery practice". (ME 21)

Societal recognition and image

The lack of recognition and status of midwifery within society was identified as a barrier to midwifery's ability to make a significant contribution to improving health outcomes. Participants identified the need for greater understanding about midwifery within the community.

"Encouraging women to get together and share their experiences of birthing and mothering is urgently needed. Working with young people in schools (adolescents) to explore their views and issues around birthing and families would help understanding and improve things for the future". (AD 11)

Strategies were frequently suggested that addressed the lack of visibility of midwifery. These included promoting public awareness and educating local doctors about the role and functions of midwives, and a call for midwifery's professional organisation to show leadership and advocate for increased recognition of midwifery within the community.

"There is an absence of any public education about midwives and keeping birth normal - this is now becoming an urgent public health issue." (SYD 22)

"We lack good quality collaboration between medical officers and midwives at the highest level. The ACMI needs to show the way!" (WB 30)

Supply of midwives

Midwives reported increasing workloads and diminished staff allocations and resources. This was most notable

when caring for women in established labour where high ratios of women to midwives and inadequate numbers of qualified staff were common. Some midwives reported inappropriate skill mix in areas where nurses without midwifery qualifications are working in midwifery without 'supervision'. In some cases, most notably in rural units, there were reports of a staff skill mix based on several enrolled nurses, one or two registered nurses and only one or two midwives. The issue of inadequate workforce numbers coupled with the falling competence and confidence of midwives was linked to concerns about the quality and safety of services.

"There is no longer a large pool of midwives to employ and train up to an adequate level of knowledge and competence. I am a senior CNS midwife who works night shift and staff shortages frequently place my clients at risk. Even at private hospitals patients are unhappy with level of care due to understaffing. Service comes at a cost - more staff please! (B 59)

Stress and workload

In identifying their concerns about the quality and outcomes of care within maternity units, some midwives detailed the consequences of working in stressful working environments. Lack of time for providing 'non-medical or non-urgent care', much of which is central to midwifery care and beneficial outcomes, was reported. This was said to lead to stress and frustration, which, for some, compounded feelings of diminishing competence and confidence. In units where workload and stress levels were continually high, morale was reported as low which in turn became an additional barrier to midwives' capacity to provide effective services.

"Management have completely unrealistic expectations regarding financial goals versus delivery of safe care. Ratio of midwife to patient is 1:8 and at night its 1:14 or 1:20. We cannot do the tasks required even for safe practice - women are suffering and at times are at risk" (SYD 10)

The 'system' of maternity care

A recurrent theme running through much of the data was the 'organisation of maternity care'. The features of this 'organisation' were seen as being reinforced by a public perception and government policy that prioritises medical responsibility for maternity care. Participants identified these two features as the main

'structural' barriers to women's access to midwifery care in both the private and public health systems. The need to increase women's ability to access midwives, most particularly in the antenatal period, were seen as two of the main strategies to improve current service provision.

"Financial structures restrict independent midwives and limit women's choices of care. In our region, women in low socio-economic situations are often having limited or even no antenatal care because their only option for care is to pay a fee for medical care. There is no midwives' clinic, there are no GPs performing obstetric care and no funding goes to midwifery models. The obstetricians have a frightening balance and use of power". (AD1)

According to participants, midwifery models in the current Australian health system are viewed as difficult to implement unless there is strong support from medical practitioners along with effective leadership and support from midwifery leaders and departmental managers. In spite of considerable evidence attesting to the potential benefits, many midwives reported tier observations of resistance to change and innovation, especially when those changes involved increased autonomy and responsibility for midwives.

"It appears to me that the heads of most hospitals i.e. Executive Committee, Directors of Nursing and the obstetricians of this country are following the American 'medical model' of high-tech care for pregnant and birthing women and ignoring proven successful women/community centred models which are based on good evidence and shown to be working elsewhere". (PO 2)

Within a milieu of medicalised maternity care, many midwives report feeling unable to practise midwifery, with an associated loss of confidence leading them into a defensive mode of practice.

"The medicalisation of childbirth and the reality/perception that consumers are becoming more litigious are the big blockers for midwifery. I now lack the confidence which I used to have and I know this leads me to do more (often unnecessary) interventions which can contribute to increased morbidity. I just can't fight it anymore" (NLR 17)

The lack of midwifery models in rural and remote areas was especially problematic for midwives in these settings. Coupled with lower birth rates and frequent requirements to also work as nurses, rural and remote midwives were particularly at risk of losing skills and

confidence in the provision of safe and effective care.

"... It is difficult for the midwife on duty to give one-on-one care to a labouring woman and maintain her skills if she is also in charge of the other patients in the hospital and the outpatient department." (AL1)

Of particular concern is the plight of remote maternity service providers.

"ACHS [Australian Council on Health Care Standards] has set standards which remote rural communities can't achieve - therefore we lose our maternity services. Clients have to travel to other (big) centres - quite long distances - for confinement. Separated from family etc. Often returning to remote community early with no follow-up in community. Hence poor breastfeeding rate etc." (NSR 10)

Midwifery Education

The two research questions did not specifically request information about education from participants. In spite of this, many responses referred to education issues when identifying barriers to midwifery service provision. Of note, were concerns expressed about the quality of new midwifery graduates who lacked the capability to 'hit the ground running'. The capacity to begin practising competently from day one was seen as an essential attribute for new graduates arriving in what were usually described as busy units, with high workloads and few resources to support, teach or mentor new staff.

"Poor preparation i.e. newly 'qualified' midwives with minimal practical skills. Please extend length of the courses to that which will produce good safe practitioners". (ME 9)

"As a junior midwife working in a large teaching hospital, the lack of midwifery educator in the labour ward has posed many challenges and problems for newly graduated midwives." (SYD 67)

The major education issues identified by participants centred on the quality of clinical placements, level of supervision of midwifery students and the lack of exposure to a full range of midwifery practice skills. In some states, students do not participate in antenatal clinics involving midwives and midwifery students and do not have exposure to practice models other than medicalised maternity care.

Many registered midwives said they were unable to access ongoing education and saw this as a major barrier to feeling confident in providing safe, efficient

effect on the capacity of midwives to contribute effectively and safely to maternity service provision. Many respondents reported lack of support and recognition from nursing managers and this was linked to a perception that midwifery professional identity and image was confused with nursing. This is particularly problematic when allocation of staff is based on the 'acuity' and 'medical' needs of patients. In maternity services, women are usually healthy and their needs may be 'invisible' when compared to acute care patients who will always have priority in any distribution of resources to enable safe care. Midwives in this study highlighted greater recognition of midwifery work as a key strategy to midwifery being able to contribute effectively to maternity services.

Many respondents identified the lack of recognition of midwifery within the community as a significant barrier. Currently in Australia, midwifery remains 'invisible' in a legal sense throughout all State and Territory Nurses Acts, (Brodie and Barclay, 2001; Bogossian, 1998; Barclay, 1985). A published review of the Nurses Act in one state recently has led to recommendations for new legislation that will allow the public to clearly identify the profession of midwifery (NSW Health Department, 2001).

Until midwives are distinguishable and accountable through regulation, the public has no way, from a legal perspective, to properly identify midwives or to determine what should be expected of their practice (Brodie and Barclay, 2001). This should be of concern because a number of maternity health care leaders and policy makers are currently seeking to maximise midwives' contributions through the development of models of care that increase midwives' role in service provision (NHMRC, 1998; NHMRC, 1996; NSW Health Department, 1996; NSW Health Department, 2000; Health Department of Western Australia, 2001; Pinch et al. 2001). At the same time, governments and health services are increasing the emphasis on consumers' participation in health service planning, delivery, monitoring and evaluation (Commonwealth of Australia, 2001). As proposed by participants in this study, a more knowledgeable and informed consumer will narrow the gap in knowledge that exists between the community and health professionals. This may lead to demand for greater choice and equity of access to maternity services, including primary care from midwives. There is now evidence of this demand being made by consumers which may herald an improvement in the public recognition of and access to services offered by midwives in Australia (Maternity Coalition and et al. 2002). As was found in South Australian research, when women have the chance to experience

midwifery care they are much more likely to chose it in subsequent pregnancies (Zadoroznyj, 2000).

The need for a clear image of what midwifery 'is', including recognition by communities, governments and funding bodies, is a key to increasing midwives' professional status, confidence and self worth. From this analysis, the midwife's identity and role appears stranded between its subsumed position within nursing, and an expectation and a professional desire to develop autonomous practice. Existing organisational structures as well as systems of education, regulation and service provision are reinforcing and sustaining both the subordination (Willis, 1983) and the invisibility of midwifery.

CONCLUSION

This study has revealed significant concerns identified by midwives that constitute barriers to midwifery being able to fulfill a legitimate role in maternity service provision in Australia. Within a context of widespread health policy change designed to address the costs and morbidity consequences of current medically dominated maternity care and the introduction of some flexible models of maternity care, midwifery's current capacity to continue to contribute is questioned. Currently, within a medically dominated health system that subordinates midwifery within nursing, the role of the midwife in Australian health services and the broader community, remains largely invisible, unrecognised and under-utilised. Within this context, lack of midwifery autonomy may be contributing to lack of job satisfaction and increasing attrition from the midwifery workforce.

If midwifery is a key to improving outcomes for women, as is evident from considerable high quality research, the need to strengthen the organisation and systems of midwifery in Australia is clear. This must include joining with women and consumer organisations in advocating for midwifery care. Midwifery is potentially central to sound public health planning (Kaufmann, 2002) and requires recognition, authority and support if it is to make an effective contribution to the provision of safe, efficient and economic maternity services in Australia at any stage in the future.

Midwives themselves have demonstrated an understanding of the wider issues and identified strategies for improvement. If these are to be realised, well-informed and skilful leadership will be required. Leadership that engages with consumers and draws on evidence and international experience to bring about

changes in the organisation of maternity services, including the funding of midwifery care and the reform of midwifery education and regulation, will go a long way towards bringing the barriers down - for women and for midwives.

Author's note

As this study was conducted during 1999 and 2000 the withdrawal of indemnity insurance for midwives was not recognised by these participants as a major 'barrier' to midwifery. It is the view of the author that lack of professional indemnity insurance has recently become a further barrier to midwifery in Australia.

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Sincere appreciation goes to those midwives and women who contributed their concerns, experiences and vision for midwifery and maternity care. Employment as a senior research midwife in AMAP enabled the author's participation in doctoral studies. The AMAP team of researchers, in particular Sally Tracy, assisted in the data collection and early development of ideas for this study. Elizabeth Nagy gave invaluable assistance in data entry. Andrea Robertson (ACE Graphics) supported the AMAP research at more than twenty different ACE seminars in 1999 and 2000.

Surveys were distributed through the journals at no cost to the researcher.

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3.2 STUDY TWO – LACK OF VISIBILITY IN REGULATION

3.2.1 Introduction

The 'Midwives Voices Study' revealed a number of concerns that constitute barriers to midwifery providing its full and legitimate role in maternity care in Australia. As identified there exists, according to midwives, a need to strengthen the organisation and systems of midwifery in Australia so that the role and expertise of midwives is widely recognised and utilised. Midwives themselves revealed certain problems and concerns with the regulation of their practice and education. This raised my concern about the impact of this on the quality and safety of maternity services overall. Researchers in Australia, including those involved in early work with AMAP had also raised concerns about a lack of consistency in the standards of midwifery education and practice regulation, suggesting a need for regulatory change (Tracy, Barclay, Brodie, 2000; Summers, 1998b).

As part of my role within the research team, I examined the eight Nurses' Acts, regulations and current policies of each state and territory in Australia, to determine their adequacy in regulating the education and practice of midwifery. It was important to explore these issues by examining the regulatory frameworks, which in any situation globally, have the potential to enhance or restrict midwifery practice. I was concerned that the current legislation was primarily for nurses and that midwives were not recognised or visible. The study was completed as part of AMAP and used the same two key questions regarding barriers to midwifery and strategies to overcome these.

Here I report on research that provided an in-depth examination and comparison of key factors in the various statutes, identifying their effect on contemporary midwifery roles and practices in Australia.

3.2.2 Context

The current regulatory system for midwives was examined in terms of its recognition of midwifery and its adequacy in protecting the public appropriately by ensuring that minimum professional standards can be met. This was of particular importance in Australia at the time of the study as, under the influences of new policy directions, and as outlined in the introduction to this portfolio, many maternity services were seeking to maximise midwives' contributions and autonomy through the development of new models of care (NHMRC, 1996; NSW Health Department,

2000a). Further, in line with developments internationally, two states were about to commence the inaugural three-year Bachelor of Midwifery into Australia (Leap, 1999). This heralded a new form of education leading to registration to practice midwifery. An analysis of the Nurses Acts and their relevance to and recognition of midwifery, as distinct from nursing, was therefore considered important. Within a milieu of legislation that considered midwifery a branch of nursing, midwifery's capacity to be recognised, visible and to contribute to mainstream maternity service provision, was examined.

Around the same time as the study was being conducted there was a highly publicised legal case in the media involving the court case of a high profile independent midwife in Sydney. She had been accused of a number of instances of malpractice and midwives and midwifery were in the news, radio and television media for many months. As the President of the NSW Midwives Association, I was expected to be a spokesperson and to give information and dispel myths about the legal status and authority of midwives. It was clear through this process that the public, as well as many journalists were ill informed about the role of midwives within the law.

As the study to examine the legislation was conceived of, discussed and further developed, my AMAP colleagues and myself became aware of the sensitivities of the work we were conducting. As part of AMAP we had occasion to attend many forums, seminars, conferences and meetings where we interacted with a large number of key stakeholders from the professional organisations for midwifery, nursing and obstetrics. These included: educators and institutions involved with midwifery training; statutory authorities responsible for the regulation of midwives; industrial bodies and consumer groups. This was an important aspect of the AMAP research that was designed to provide information to health departments, health services, universities and regulatory bodies to co-ordinate planning and improve the implementation of midwifery practice and maternity care. Of note to those of us involved in questioning the relevance and quality of the current legislation, was the significant resistance we felt in our efforts to engage others, particular many nurse leaders in the perceived 'problem'. By posing the questions [about the adequacy or otherwise of current legislation] at a variety of professional conferences, forums and meetings we experienced firsthand where the resistance and opposition to our challenges came from. Many nurse leaders became anxious and upset with any notion that midwifery might seek separate recognition from nursing in Australia. Some chose to distance themselves from the debate. Others engaged with,

explored and listened to, the issues raised and this assisted the AMAP work with their clarity, vision and insights. Significantly, as representatives of two industry partners who contributed funding to the study, two State health department chief nurses actively explored and examined the issues in detail and contributed vital input to the discussions.

Around this time moves towards mutual recognition of qualifications (Commonwealth of Australia, 1992) were beginning to pose complex questions of comparability of training and expertise between Australian states and New Zealand, particularly in relation to direct-entry midwives who were not nurses. These changes in policy and regulation were also occurring amidst increasing challenge to the legal liability of midwives and the expectation that affordable professional liability insurance for independent midwives would no longer be provided by insurers.

As such we were challenged, from several different perspectives, to explore the issues in detail whilst not marginalizing colleagues and leaders who may well be charged with the responsibility for implementation any of our recommendations. As part of the process, I endeavoured to discuss my findings at every opportunity, and to listen to the perspectives of others.

Nonetheless, we argued that midwifery is essentially invisible within current legislation and that there is a need for urgent political and policy intervention including resource allocation and regulatory reform. This is necessary, not only so that the Acts can legitimately recognise and make visible midwifery, but also so that the expressed needs of consumers to gain access to midwifery care can be met.

In the following pages the full paper that was published in the peer reviewed journal, the Australian Health Review in December 2001 (Brodie and Barclay, 2001) is provided.

3.2.3 The Regulation Publication

Brodie P and Barclay L (2001) Contemporary Issues in Australian Midwifery Regulation Australian Health Review Vol. 24 No 4 pp 103-118

Contemporary issues in Australian midwifery regulation

Contemporary issues in Australian midwifery regulation

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Abstract

This paper reports on research that examined the Nurses' Acts, regulations and current policies of each state and territory in Australia, in order to determine their adequacy in regulating the education and practice of midwifery. This is part of a three-year study (Australian Midwifery Action Project) set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia. Through an in-depth examination and comparison of key factors in the various statutes, the paper identifies their effect on contemporary midwifery roles and practices.

The work assessed whether the current regulatory system that subsumes midwifery into nursing is adequate in protecting the public appropriately and ensuring that minimum professional standards are met. This is of particular importance in Australia, where many maternity health care services are seeking to maximise midwives' contributions through the development of new models of care that increase midwives' autonomy and level of accountability.

A lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally are identified. When these are considered alongside the planned development of a three-year Bachelor of Midwifery, due to be introduced into Australia in mid-2002, there exists an urgent need for regulatory change. The need is also identified for appropriate national midwifery competency standards that meet consumer, employer and practitioner expectations, which can be used to guide state and territory regulations.

We argue the importance of a need for change in the view and legal positioning of the Australian Nursing Council and all Nurses Boards regarding the identification of midwifery as distinct from nursing, and substantiate it with a rationale for a national and consistent approach to midwifery regulation.

Introduction

It is timely to review the current system of midwifery regulation in Australia. In the last decade the organisation and context for the provision of maternity services has changed considerably.

Major shifts in government policy direction and reforms across maternity care services have occurred as a response to community demand and evidence of the safety and satisfaction with midwifery care (Homer et al. 2001; Kenny et al. 1994; Rowley et al. 1995). As a result, new models of care have emerged that require midwives to work in more flexible arrangements rather than the 'shifts' of the traditional eight-hour salaried employee.

New working conditions are emerging reflecting increased autonomy and self regulation of practice and standards (Department of Human Services 1999a; Department of Human Services 1999b; NHMRC 1996; NHMRC 1998; NSW Health Department 1989; NSW Health Department 2000; Victorian Department of

Health 1990). Compounding this internationally and nationally is the increasing prominence of undergraduate (non-nursing) programs in midwifery.

The United Kingdom (UK) now prepares the majority of midwives in comprehensive three-year and four-year programs (Fraser 2000). Other Western countries such as the Netherlands, France, Denmark, Germany and Sweden have always educated midwives through three and four-year programs. These countries report some of the best standards of practice and clinical outcomes in maternity care in the world (Campbell & Macfarlane 1994; McKay 1993; Tew 1990).

In New Zealand, all one-year midwifery programs have now ceased. Nurses themselves who considered that their one-year program was inadequate in comparison to the three-year midwifery program initiated this action (Personal communication, Pairman 2000). With an increasing emphasis world-wide on the use of evidence to inform practice, policy making and the organisation of services, the midwifery profession is challenged to change and develop, in order to meet the needs of the community, governments and employers.

The changes described above have the potential to significantly affect the way midwifery is regulated and organised in Australia. Since World War II, midwifery has been predominantly based in acute care hospitals and within nursing models of organisation and management (Barclay 1986). Changes to practice, education and regulation will be necessary if contemporary Australian midwives are to meet these demands and if the standard of midwifery care offered to Australian women is to be comparable to other Western countries.

The necessity for rethinking the regulation of practice to keep pace with changes in the organisation of health care and the role and scope of practice of the midwifery profession is obvious. This paper provides an overview of the regulation of midwifery in Australia. It examines and compares key factors in the various state and territory Acts, to identify their effect on contemporary midwifery roles and practices. The work aims to test whether subsuming midwifery into nursing within the current regulatory system protects the public and ensures professional standards are met. This is of particular importance in the current health care climate that is seeking to maximise midwives' contributions and expand their autonomy and level of accountability (Commonwealth Department of Health and Aged Care 1999; NHMRC 1996; NHMRC 1998; NSW Health Department 2000). A regulatory framework is required that clearly identifies midwifery and enables the necessary health services reform to occur in a manner that both protects the public and enables the appropriate education of the profession.

Background

In Australia, midwives and childbearing women have historically not had a strong voice in planning and implementing regulatory systems and public health policy (Barclay 1984; Barclay 1985a; Barclay 1995; Summers 1998). Midwifery has been subsumed into nursing since regulatory systems for nurses were set up in the 1920s (Bogossian 1998; Summers 1998). With few exceptions, nursing leaders have been required or have chosen to represent both nursing and midwifery and the interests of nursing have been privileged. Midwifery has been seen post World War II, as just one of the many specialities of nursing, similar to for example mental health, paediatrics or aged care (Barclay 1986). This has meant that, despite all the evidence linking improved maternal and infant health outcomes with autonomous midwifery practice (Department of Health Expert Maternity Group. 1993; Katz-Rothman 1991; World Health Organisation 1996), midwifery has declined as a separate profession since the 1920s and 1930s. Enactment of single nursing registers within some state and territory Nurses Acts over the past decade has further compounded this issue. Through the various Nurses Acts and regulations, reviewed in the 1980's (Barclay 1985b), in the 1990s (Bogossian 1998) and again for this paper, midwifery has remained 'invisible' in a legal sense in Australia.

In contrast, in many western countries midwifery has always been recognised as a discipline distinct from nursing. Recently, some countries such as the United Kingdom and Ireland have reasserted the value of this distinction (UKCC 1998; Government of Ireland 1998). The current UK registration statute is titled the *Nurses, Midwives & Health Visitors' Act (1998)*, which clearly recognises the distinction between these disciplines. A recent major review of this Act has highlighted the need to:

"ensure that the public protection afforded by the Act is effective while not stifling developments in health care" (UK Health Department and JM Consultancy Ltd 1998), p6).

The midwifery profession in Australia is currently questioning inconsistencies and apparent failures of the current regulatory and education systems for midwives (Summers 1998; Tracy, Barclay, & Brodie 2000; Waldenstrom 1996). This follows serious concerns identified more than fifteen years ago (Barclay 1984; Barclay 1995) which, while continuing to be raised through a number of different forums (NSW Health Department 1989), have received insufficient attention from regulatory bodies, funders and policy makers (Commonwealth Department of Health and Aged Care 1999; NSW Health Department 1989; NSW Health Department 1998; NSW Health Department 2000; NSW Health Department 2000). These concerns are exacerbated by, and should be considered in the light of, the move from hospital-based midwifery education to the tertiary sector and an absence of any formal evaluation or analysis of the impact of this move on standards of care and practice.

The consequences of changing service delivery models and the shifting of health care from hospitals to the community, a common trend in many western countries, alter the role, scope of practice and education of midwives. Australia's high standard of maternity care assumes the presence of qualified midwives. They offer safety and support for women in childbirth and the postnatal period in collaboration with medical colleagues, and increasingly as primary providers of maternity care in their own right (NHMRC 1996; Australian Medical Workforce Advisory Committee 1998).

Concerns about the educational standards of midwives are also associated with global changes and reforms in the way midwifery is regulated (Department of Health UK 1998; Jowitt 2000; Lilford 1993; Norman 1998; Rogers & Ryan 2001; UK Health Department and JM Consultancy Ltd 1998). The highest standards should be employed in the regulation of both midwifery and nursing in order to optimise protection of the public and to promote and maintain public trust and confidence with the professions. Across Australia, the regulatory Boards (In this paper Nurses' 'Boards' includes the Queensland Nursing Council) of each state and territory regularly review their systems and processes in order to meet their objects. Boards have a key responsibility to communicate to consumers the competency standards that they can expect of nurses and midwives (Australian Nursing Council Inc. 2001).

Through these endeavours the Australian Nurses' Boards aim to promote consumer involvement, high professional standards, greater protection for the public and better regulatory practice. There are however profound differences in the way this is done. The results and comparability of current processes in a climate of mutual recognition is problematic. It is timely that a more modern regulatory framework that encompasses self-regulation, personal accountability and agreed national standards be developed.

Aim

The aim of the research reported in this paper was to analyse the Nurses' Acts, regulations and current policies of each state and territory to determine their adequacy in regulating the education and practice of midwifery in Australia.

Method

Each of the eight statutes were obtained electronically and downloaded from The Australasian Legal Information database (AustLII). These were analysed for similarities and consistency in structure, format, content and relevance. An overview of the current legislation that regulates midwifery in all states and territories was constructed from this data.

A systematic content analysis that included the search for the basic attributes and common features found in most forms of professional regulation was conducted.

Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. Diversity within these basic attributes and their relative importance to each other was analysed and reported only when this appears to have negative consequences or outcome. A comparison of midwifery regulation documents from the United Kingdom, Europe and New Zealand, as well as some of the recent published literature, was made to verify assumptions and contrast Australia with international standards of midwifery education and practice.

The authors consulted with a nurse-lawyer, which enabled a number of inconsistencies and anomalies to be identified. This resulted in the drawing of a number of conclusions about the Acts and regulations as they currently exist including certain limitations and concerns.

Two key questions were asked of the regulations:

- What are the current laws, regulations and policies, which govern midwifery practice and education and how do they compare between states and internationally?
- What are the features of the current system of regulation of education, practice and competency of the midwifery profession?

The authors hypothesised that, within the current system of nursing regulation through the state and territory Boards, there is confusion about the role of the midwife with a lack of consistency that challenges the legitimacy of the current Acts and their capacity to protect the public.

Results

Midwifery education regulation

Currently there is wide discrepancy between midwifery educational programs across the country with concerns that current midwifery programs in Australia do not meet recognised international competency standards for midwives (Leap 1999a) (AMAP unpublished data, July 2001) or even nationally agreed baselines. This is confirmed by examination of state and territory regulations with regard to approval of courses and institutions. For example, in New South Wales, all students of midwifery are required to meet the particular competencies of a midwife as set out by the Board plus complete a list of clinical requirements including twenty births, twenty abdominal palpations and ten vaginal examinations (Nurses Registration Board of NSW 2000). In some states however, such as South Australia, Western Australia and Queensland competency based assessment of students has completely replaced a system of minimum clinical requirements for qualification. In South Australia, student midwives are assessed through a 'competency-based approach' that does not stipulate a specific number of clinical requirements, hours or shifts in a particular area (Glover, James, & Byrne 2001). The Nurses Board of Northern Territory require midwifery students to master three skills, chosen from a list of six or eight, in each of four different clinical areas (Nurses Board of Northern Territory 1989). Unpublished data reports that some midwives have been able to register after completing as few as five births (AMAP data, unpublished 2001). One recent publication reports how graduates educated through this 'competency based approach' may not be employable as midwives in the same small country hospital where they completed their clinical placement because they are not considered to have enough experience (Glover, James, & Byrne 2001).

There is a wide range of clinical practice requirements, which are developed locally by each Board through 'consultative' processes. These vary and they reflect the priorities and expectations of the individual group, rather than any agreed national formula or standard for consultation and review. Large differences in the number of theoretical and clinical hours of programs are also compounded by the variability that exists in the amount and type of clinical experience available to students. In addition, in the absence of national standards, labour force shortages make these local processes vulnerable to manipulation, with potential to undermine practice standards even further. The Australian Midwifery Action Project (AMAP) is conducting a survey of all universities currently offering midwifery education leading to authority to practice. This research will highlight the lack of comparability of current midwifery curricula, including number of clinical and theoretical hours, assessment of competency, duration of course and nomenclature of awards.

To date, the Australian nurses boards have not been able to agree on universal adoption of the Australian College of Midwives Competency Standards for Midwives (Australian College of Midwives Inc. 1998). By late 2001, three out of eight Boards (New South Wales, Western Australia and Northern Territory) had not adopted the midwifery competencies specifically developed by the profession (Personal communication, ACMI, 2001). This is problematic though not surprising given the variable composition of the Boards, the lack of consistency with regard to midwifery representation and the wide variation in standards of regulation. Table 1 shows how the various Boards are constituted with only two states, NSW and WA specifically requiring within the Act that a midwife actually be a member of the Nurses Board (Nurses Board of Western Australia 1992; Nurses Registration Board of NSW 1991).

Table 1: Composition and structure of the eight Nurses Boards and Councils including level of midwifery representation

State/Territory	Constitution of the Board	Chairperson of the Board
Australian Capital Territory	Chairperson + 4 other members not more than 2 to be EN appointed + 4 members elected in accordance with Health Professionals Boards (Elections) Act. Must be RN or EN entitled to practise as such for 3 years in any State or Territory prior to this time	Must be RN as does deputy
New South Wales	13 members appointed by Governor: 3 elected RNs; 1 EN; 1 RN authorised to practise midwifery; 1 RN from NSW Nurse's Association; 1 RN from NSW College of Nursing; 1 RN from Minister of Health; 1 RN educator of nurses, nominated jointly by Minister School Ed & Youth Affairs and Minister of Further education, Training and Employment; 1 RN Psych nurse, nominated by Minister; 1 barrister or solicitor; 2 consumers	Not specified
Northern Territory	8 members: RN responsible to Chief MO for nursing services in Territory; Person in charge of medical services at Darwin Hospital; RN in charge of nursing at Alice Springs Hospital; RN in charge of nursing services at Darwin Hospital; 4 persons appointed - 1 RN, 1 qualified practising nurse educator; 1 RN and 1 EN nominated by ANF	RN responsible to the Chief Medical Officer for nursing services in Territory
Queensland	13 members: 5 RNs; 5 nurses chosen from panel of names submitted by associations accepted by Minister as representatives of nurses; 1 consumer; 1 lawyer; Executive officer of the council	Governor in Council appoints member of the board who is not an officer of the public service
South Australia	11 members: 1 RN nominated by Minister - presiding member; 5 RN or EN elected; 1 Medical practitioner; 1 lawyer; 3 people nominated by Minister who are not nurses, lawyers or doctors, at least one woman and one man	Appointed by Minister
Victoria	12 members: 9 must be RN - 2 must be registered under Division 2; 1 lawyer; 2 non nurses	President and Deputy appointed by the Governor in council, must be RNs
Western Australia	12 members appointed by the Minister: 2 ANF ¹ midwife ² ; 1 Psych nurse ³ ; 1 RCNA WA ⁴ ; 2 EN ⁵ ; 1 TAFE ⁶ ; 1 Curtin ⁷ ; 1 Edith Cowan ⁸ ; 1 Minister Consumer Affairs ⁹ ; All members to be natural persons and have 3 years standing in practice	Presiding member appointed from members by Minister and after consultation with the Board
Tasmania	7 members nominated by the Minister and appointed by the Governor: 5 practising nurses with ability to fulfil the Board's objectives; 2 persons who are not nurses who represent the interests of persons who use the services of nurses.	A practising nurse, appointed by the governor

Explanations for Table 1:

1. Australian Nursing Federation nominates two representatives who are registered on Division 1 of the register
2. The Australian College of Midwives Incorporated (WA Branch) nominate a person with knowledge of and experience in midwifery and who is registered on Division 1 of the Register.
3. The Psychiatric Nurses Association nominate one representative
4. Royal College of Nursing WA Chapter nominate one representative with knowledge and experience in nursing administration

5. The Federated Miscellaneous Workers Union of Australia nominates two representatives who are enrolled nurses
6. The Executive Director of TAFE nominate one representative who has knowledge and experience teaching nurses to be registered under Division 2
7. The Chancellor of Curtin University nominates one representative who teaches nursing at that university
8. The Council of Edith Cowan University nominates one representative who teaches nursing at that university
9. Minister, Consumer Affairs nominates one person who has consumer representation experience

In a climate of maternity services reform with increasing prominence of midwifery, it is inappropriate for Boards to continue to state that the conceptual framework and course philosophy for midwifery education programs must have a 'nursing focus' (Nurses Board of South Australia 1997; Nurses Board of Western Australia 1993). Similarly, regulations that require curricula based on 'nursing theory and practice', with teachers of programs having a 'nursing background' (Queensland Nursing Council 1993; Nurses Board of South Australia 1997), are out of step with contemporary practice. Quite apart from the impact on content and syllabus, this terminology alone, emphasises inconsistencies of Australian regulation with midwifery education nationally and internationally.

This approach does not ensure that the community is either protected through practice or receive optimally educated practitioners. It also disadvantages both students and universities in terms of potential international exchanges, recruitment of high quality academics and the marketing of courses in other countries. There are also concerns about how these issues contribute to a situation where Australian midwives, unlike nurses or medical practitioners, routinely have to undertake further education if they wish to practise in other countries (Leap 1999b).

Reviews of midwifery educational and clinical facilities conducted by the Boards are not required by all states. Where they are required (Nurses Board of Western Australia 1993; Nurses Registration Board of NSW 1997), there is no consistency in requirements for how these visits are to be performed or the qualifications of persons performing them. There is no evidence of any formal link or expected compliance between states and territories. This is in spite of the Australian Nursing Council Incorporated (ANCI) stating that one of its key functions is to:

'lead a national approach with State and Territory nurse regulatory authorities in evolving standards for statutory nurse regulation which are flexible, effective and responsive to health care requirements of the Australian population'

(Australian Nursing Council Inc. 2001).

In contrast, in the United Kingdom, Canada and New Zealand regulatory Boards use agreed national criteria to accredit curricula as well as teachers, facilities and services. Robust validation of standards of midwifery education and midwifery practice settings, determined by the profession, in consultation with consumers and in keeping with changes and new directions in health service delivery, is expected (English National Board for Nursing 1998; Nursing Council of New Zealand 1996; Ontario College of Midwives 2001). In addition in the UK, health care facilities are required to demonstrate evidence of 'keeping up to date with government policy direction and principles of care' (English National Board for Nursing 1998).

Concerns with the quality of the current Australian midwifery workforce have recently been articulated (Tracy, Barclay, & Brodie 2000; Waldenstrom 1996) and these will require addressing within the regulations as well as by education and service providers as well as professional bodies¹. All current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries, for example the requirement in Europe for midwives to participate in at least 40 births (European Community Midwives Directives 1980) and in Canada 60 births (Ontario College of Midwives 2001), before receiving registration.

It is crucial that agreed standards in education are established nationally that are consistent across curriculum and regulation and that provide the baseline for ongoing practice regulation.

Midwifery practice regulation

Practice standards are another important aspect of regulation and exist alongside the growing emphasis upon quality assurance and evidence based protocols and policy in health care.

In Australia, course accreditation standards, evaluation systems and processes to ensure standards of midwifery and nursing education and practice, vary from state to state. There is not an explicit link, agreed minimum standards or any benchmarking possible between the different Boards, as might be expected through the examination of regulations. This is not 'managed' consistently either, with some Boards or Councils for example, not having an identified professional officer in midwifery or even an equivalent person responsible for midwifery as one of several portfolios. Arguably, Board personnel with a broad generalist role would not be able to keep up to date with relevant issues such as evidence based midwifery practice and policy development.

Two of the key objectives of the Australian Nursing Council are to:

- develop and be guided by a strategic view of statutory nurse regulation in the national and international contexts;
- apply a continuous quality improvement approach to its activities (Australian Nursing Council Inc. 2001).

The actual structure, processes and outcomes related to these objectives with regard to midwifery practice is not evident in the current legislative documents available to the profession and the public. See for example the Annual Report of the Australian Nursing Council Inc. (2000) and the website of the Council (Australian Nursing Council Inc. 2001) in which midwifery is not identified at all.

Identification and recognition of midwifery

All Nurses Acts in Australia currently see midwifery as a 'branch' or 'specialty' of nursing and therefore refer to midwives as nurses. This has serious implications for the regulation of those midwives who have never been nurses and who would not seek to hold themselves out as nurses. There are anecdotal reports of increasing numbers of 'direct entry' midwives from countries such as England, New Zealand and Canada seeking registration in Australia. In some cases these persons are being 'licensed' to practise both as midwives and as nurses. In one case, a midwife who was refused registration in one state in Australia proceeded to obtain registration in New Zealand without difficulty. Under mutual recognition (Commonwealth of Australia 1992), this midwife could register in her new home state in Australia who had originally refused to register her. (Personal Communication, 2000).

In all but three states, midwives are automatically presumed to be competent as a nurse and practise under a Nurses Code of Ethics. To date, three states (Victoria, Queensland and Tasmania) have also developed their own individual codes of practice for midwives (Nurses Board of Victoria 1999; Nursing Board of Tasmania 2000; Queensland Nursing Council 2000). It is unreasonable, unsafe and probably unlawful to expect people who have never identified as nurses to self regulate as nurses within documentation that, in some parts of Australia, does not explicitly include the nomenclature of midwifery and midwife. It is therefore inappropriate to simply suggest within the statutes that nomenclature for midwife/midwifery may be used interchangeably with nurse/nursing (Nurses Board of South Australia 1999). It is unacceptable, irrelevant and arguably dishonest to ask a midwife at registration, to describe her/his previous experience as a nurse when, she/he has only ever worked as a midwife. Increasingly, this also applies to midwives who no longer work in nursing and identify solely as midwives, and to midwives who have only very occasional access to midwifery practice.

Each of the state and territory Acts provide for the Boards to have specific powers enabling the practice of midwifery to be 'controlled'. These powers appear to be directed at controlling any attempt by non authorised persons from practising midwifery, although midwifery practice itself is not defined. In all states midwifery requires a separate authorisation from the Board, following registration as a nurse. Practising midwifery is illegal unless the person is a medical practitioner, or a student nurse, midwife or doctor 'under supervision'. Where the term 'supervision' is used, it is not always defined. Only the Nursing Acts of Tasmania (1995) and South Australia (1999) attempt to do so by providing an interpretation of the term 'supervision' to include: "oversight, direction, guidance and support" with the South Australian Act (1999) adding to this.... "whether given directly

or indirectly". The New South Wales Nurses Act (Nurses Registration Board of NSW 1991) states that a person must not practise midwifery without authorisation unless they are a medical practitioner, a person rendering emergency care or:

"any medical or nursing student, or accredited nurse, acting under the supervision of a registered nurse authorised to practise midwifery, or the supervision of a medical practitioner"
(NSW Nurses Act 1991 Part 2 Section 7).

The public have no way of determining the efficacy and safety of particular arrangements that may be under the auspices of midwifery 'supervision'. It is important that consumers are able to identify qualified persons and make 'informed choices' around their maternity care options, particularly in NSW where they may be receiving care from 'any' level of nurse or medical student under 'supervision' (NSW Nurses Act 1991 Part 2 Section 7). Protection of title is important in contributing to the public's perception of the distinction between the professions of nursing and midwifery. As stated in the NSW Health Issues Paper (NSW Health Department 1999) specifically prepared to assist in a review of the Nurses Act in that state:

"The objective of title restriction is to protect the public by ensuring that consumers are able to identify qualified persons" (p26).

In addition to protection of the title 'nurse', which is universal in Australia, four states (NSW, ACT, Victoria and SA) restrict the use of the title 'midwife'. Protection of title is of little use if the documentation produced by the Boards, is confused and implies that nurses and midwives are one and the same. For example, whilst not enshrined within law, the Boards of NSW and Tasmania both state that they 'accept' the current definition of a midwife as endorsed by the World Health Organisation (Nurses Registration Board of NSW 2000; Nursing Board of Tasmania 2000). Significantly, this definition states that "a midwife is a person" and does not in any way state that a midwife must also be nurse (International Confederation of Midwives 1990).

Table 2: Purpose of the Act and nomenclature used for recognition of nurse, nursing, midwife and midwifery for each for each state and territory

Act	Purpose of Act	Interpretations within the documents
New South Wales 1991	To regulate the practice of nursing and to repeal the Nurses Registration Act 1953	RN: person reg. under this Act. Person authorised to practise midwifery must be entitled to be registered nurse
Australian Capital Territory 1988	To provide for the registration & enrolment of nurses, supervision of nursing education and standards, and related purposes	RN: person reg. as general nurse, mental health nurse, or midwife; 'practising' in this Act means practising in any branch of nursing
Northern Territory 1984	To provide for schools of nursing and the registration and enrolment of nurses	Nurse: person reg. or enrolled under the Act. General nurse: person whose name appears on the registry under general category of nursing. Midwifery nurse as above but on category of midwifery.
Queensland 1992	To provide for registration and enrolment; practice of nursing, education of nursing and related purposes S 3 Objective : to make provision for ensuring safe and competent nursing practice	Nurse: registered or enrolled nurse. Midwife: person authorised to practise midwifery. Nursing Course: course to educate persons in nursing and midwifery. Nursing Practice: includes midwifery, psychiatric, and any other area of nursing practice. Nursing qualifications: includes midwifery, psychiatric and any other area of nursing.
South Australia 1999	To provide for Registration and enrolment of nurses, regulate nursing for purpose of maintaining high standards of competencies & conduct by nurses, to repeal 1984 Act, other purposes	Nurse: person reg or enrolled under Act. Midwife: person authorised under this Act to practise midwifery. Midwifery: care assistance, or support provided to a mother or child in relation to pregnancy or the birth of a child. Special practice areas: midwifery, mental health nursing, any other area of nursing recognised by the Board as being special practice area
Victoria 1993	To protect public by providing registration for nurses & investigation into professional conduct and fitness to practise of RN; to establish Vic Nurses Board; repeal 1958 Act, to provide for other related matters	General nurse / maternal and child health nurse / midwife means person registered under Division 1 of the register;
Western Australia 1992	To provide for regulation of the practice of nursing, registration of persons as nurses, repeal 1968 Act and related purposes	Nurse: a person registered; Speciality means a particular branch of nursing recognised by the Board as requiring particular qualifications approved by the Board
Tasmania 1995	To provide for the registration and enrolment of nurses, the regulation and practice of nursing, the repeal of the Nursing Act 1987 and for related purposes	Nurse: a person registered or enrolled as a nurse; midwife means a registered nurse authorised to practise midwifery; practise means practise nursing; midwifery is a restricted area of nursing practice

The need for a clear distinction between midwifery and nursing is underpinned by the fact that, following completion of an appropriate educational preparation and registration within the Act, midwives are *practitioners in their own right*. This differs for all other areas defined as specialities in nursing. Within the Acts, midwives are not required to consult with doctors unless there is a medical need. Midwives are qualified to provide primary care across a clearly defined spectrum of time in a woman's life. The period of care is usually the antenatal, intra-natal and postnatal period up to either twenty eight days or six weeks following childbirth. In most developed countries other than Australia, this period of time is explicit within the regulations which make provision for midwives to have legal responsibility for this clear and well defined sphere of practice (UKCC 1998).

The internationally recognised definition of a midwife states that:

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

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service". (International Confederation of Midwives 1990).

Other issues of quality in regulation

Determination of recency of practice is another area of regulation where there is significant inconsistency between the various regulatory systems. In some states registration continues indefinitely, even if a midwife is no longer practising or has not practised for many years (Nurses Registration Board of NSW 1991). 'Practising' is not defined or clearly identified as 'clinical practice' although one authority provides a 'limited' registration to allow for research or teaching only (Nursing Board of Tasmania 1999). Every state except NSW has a '5 year clause' that requires a midwife to complete a re-entry program (often in nursing). Most allow continuation of registration as a midwife even if working exclusively as a nurse with an implied assumption that practising as a nurse also keeps an individual up to date in midwifery. Whilst it may be argued that recency of practice is the responsibility of the individual and/or the employing authority, in the current climate of workforce shortages, it is possible that such expectations are not consistently adhered to. Similarly, in such situations of workforce shortages, midwives who have not practised nursing for many years, or even not at all, may be sent to work in nursing areas. Again, protection of the public and adequacy of regulatory standards is questionable and should be a matter for concern.

To date there is not universal agreement regarding nationally competency standards for midwifery practice or education in Australia, and as such continuing professional competence is addressed in a variety of different ways by each of the Boards. In some states (for example SA), midwives are required to declare competence as a nurse using the Board approved competency standards for the registered nurse (Australian Nursing Council Inc. 1998). The principle mandate of the ANCI (of which all state and territory Nurse Boards are stakeholders), is to lead a national approach in developing common standards for statutory nurse regulation. Since inception and to date the ANCI have shown no evidence of endorsing national standards for midwifery practice or education. ANCI continue to utilise nursing standards in their assessment of overseas applicant's suitability for registration and competence to practice midwifery, and in assessment of the midwifery educational programs these applicants have undertaken. This is inconsistent with the contemporary international approach to midwifery regulation.

Currently, only one Board requires practising midwives to declare competency on an annual basis using the ACMI Competency Standards for Midwives as the standard (Australian College of Midwives Inc. 1998; Nursing Board of Tasmania 1999). Of concern is one Board (NSW) that does not require nurses or midwives to declare any degree of competence before receiving annual renewal of registration.

Concerns about the regulatory standards of education of new midwives may also be applied to the re-education of midwives returning to the workforce. Currently, in Australia there is no evidence of any requirement for refresher programs to be of a certain standard with regard to content, duration or outcome measures. In 2000 a change in the Tasmanian regulatory framework demonstrated how many midwives do not re-register when stringent mechanisms are put in place that require them to declare competence in their field. Section 5.2 in the code of Practice for Midwives in Tasmania states:

"All midwives are responsible and accountable for their own practice. They must act within the sphere of midwifery practice and are expected to maintain the necessary competence for safe and effective practice. The standard in Tasmania is the ACMI Competency Standards for Midwives". (Nursing Board of Tasmania 2000).

In one year following the release of the Competence to Practise Policy (Nursing Board of Tasmania 1999) the numbers of practising midwives registered in Tasmania dropped markedly (Street 1998). This is further evidence that loose legislation is not enabling the Boards to meet the objectives of the Act. This action also adds strength to the argument that midwives or nurses will choose not to work in areas where they are not recently familiar or competent, when given the opportunity to declare their self competence and individual scope of practice for safe care. Table 3 describes current regulation standards by State and Territory regarding declaration of competence, existence of a code of practice for midwifery, and recency of practice requirements for midwives in Australia.

Table 3: Annual declaration of competence requirements, existence of recency of practice clause and code of practice for midwives in Australia, by State and Territory..

State/Territory	NSW	NT	ACT	QLD	VIC	SA	WA	TAS
Annual declaration of competence required -	no	no	no	yes	yes	yes	no	yes
Type of competency: Ns = nurse Mid =midwife	-	-	-	Ns	Ns	Mid	-	Mid
Recency of practice clause (5 years)	no	yes	yes	yes	yes	yes	yes	yes
Code of practice for midwives	no	no	no	yes	yes	no	no	yes

The issues of recency of practice and continuing competence are both complex and important. In terms of protecting the public this should reflect a national standard to allow for the mutual recognition of accreditation from other states and territories around Australia. It appears essential that Australia moves toward a national system whereby midwives and nurses must declare that they have maintained competence in one or both disciplines and that they have determined for themselves that they are safe to practise. The Acts should ensure that standards are employed rigorously and appropriately in the regulation of both professions in order to protect the public and promote and maintain standards of care. This is an important principle if Boards do not see their role to monitor practice standards in any other way. These issues raise significant questions surrounding refresher and re-entry programs including who provides them, as well as costs, content, standards and audit and quality measures in place.

Employers need to be able to expect that a midwife registered in another state is of a similar standard to that expected in the state in which they seek to practise. This is assumed to be more straightforward since the Mutual Recognition legislation was enacted in 1992 (Commonwealth of Australia 1992). This Act was introduced to address some of the difficulties created by state and territory differences and to facilitate the registration process for health professionals moving across borders. The effect of this legislation was supposedly to provide uniformity and consistency in addressing prerequisites for registration and streamlining the process of registration for practitioners who moved from one state to another. Despite this Act, there remain significant differences in the relevant legislation between the states and territories that is highly problematic. Similar concerns have recently been raised regarding the regulation of nursing in Australia in which the author identifies the need for the development of a national template for the regulation of all health professionals (Bryant 2001).

Current context

There is recognition by some employers as well as researchers of the need for the standard of midwifery education to be reviewed in light of developments in models of care, as well as concerns about standards of practice and recruitment and retention of midwives (Tracy, Barclay, & Brodie 2000). Under the auspices of the Australian College of Midwives (ACMI) several universities across Australia are developing innovative collaborative approaches to midwifery education that include a set of national standards for the accreditation of three-year Bachelor of Midwifery programs. This form of midwifery education will be developed in Australia over the next few years, with eight Universities reporting that they intend to commence three-year programs in 2002 and 2003 (Australian College of Midwives Inc. 2001; Leap 2001). In March 2001, the Australian College of Midwives (ACMI) Bachelor of Midwifery National Taskforce distributed in draft form, *Standards for the Accreditation of Bachelor of Midwifery Programs* to the eight Nurses Boards. This is part of the ACMI's attempt to develop standards and a national framework to ensure excellence and compatibility in the accreditation of midwifery education programs used across the country. It is hoped that eventually, these standards will be used for approval of all courses and education providers in all institutions offering courses leading to registration as a midwife. At the current time however, as the current Acts are constituted, Nurses Boards are not obligated to adopt these standards. It is proposed that a peer review panel constituted and convened by the ACMI will make recommendations to the registering authorities for course approval (ACMI, Personal communication, 2001). This most significant and formal attempt by the midwifery profession to seek national recognition of midwifery standards and competence will challenge the current regulatory system and further highlight its limited capacity to respond at a national level.

Conclusion

It is clear from the analysis of the various acts and regulations affecting midwifery in Australia that serious inadequacies exist. The lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally, raise concerns about the capacity of the current statutes to protect the public adequately and ensure that minimum professional standards are met.

The development of national standards in midwifery education and a three-year Bachelor of Midwifery intensify the urgent need for regulatory change to bring Australia into line with other Western countries. Appropriate national midwifery competency standards that meet consumer and practitioner expectations and that can be used to guide state and territory regulations, are urgently needed.

Membership of the ANCI and all Boards of the future will need to recognise midwifery as distinct from nursing in order to ensure that 'profession specific' issues are addressed by the relevant group, with involvement of all key stakeholders. Midwifery and consumer representation should be evident on all bodies concerned with midwifery practice and education standards as well as with peer review and complaint mechanisms regarding the professional conduct of midwives. Currently this is neither consistent nor effective nationally. Specific midwifery representation is reflected in various ways, through board membership, the existence or otherwise of practice review committees and ad hoc processes of consultation with the professional midwifery and consumer groups.

The Boards have a role to play in educating the public to understand regulation and to enable discrimination regarding the significance of the title 'midwife' in terms of the role, as well as the different body of knowledge and scope of practice of midwives. The public needs to be aware if they are receiving care from a midwife, a nurse, a doctor or a student of any health profession. Protection of title is of little importance unless the public is educated to understand the significance of the title and how they are protected under the Act. Nomenclature should be addressed so that midwifery practice is clearly identified and to enable the regulation of midwives who are not nurses or who are no longer or have never been competent to practise in both professions. The skills and practices of each profession are distinct and different and the public has a right to this information. Any revision of regulation should ensure that the nomenclature refers to nursing or midwifery distinctively so that the public and employers can be properly informed.

The ANCI have been responsible for a range of initiatives that demonstrate their commitment to and achievements for the profession of nursing. These include the development of a Code of Ethics for Nurses; a Code of Professional Conduct for Nurses and National Nursing Competency Standards for the Registered and Enrolled Nurse. It is essential that these same endeavours occur for the midwifery profession, for both midwives and consumers of maternity care across Australia. Universal adoption of the ACMI Competency Standards for midwives and a national Code of Practice and Code of Ethics for midwives would be an appropriate move forward in addressing some of the inadequacies and discrepancies identified. If self-assessment of competence is to be adopted universally, processes of maintenance and self-declaration must be established and recognised as national minimum standards. It would be desirable for the Boards, in partnership with ACMI, to explore these as well as the international systems and mechanisms for maintenance of midwifery standards to determine what constitutes appropriate professional activity and the best way forward regarding policy on these crucial issues.

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World Health Organisation 1996, *Care in normal birth: a practical guide* Maternal and Newborn Health/Safe Motherhood Unit, Family and Reproductive Health, WHO., Geneva.

3.2.4 A Challenge to the authors of the Study

During the preparation of the paper for publication we had deliberated as to which journal would be the most appropriate and effective in terms of disseminating the messages it contained. We decided on the Australian Health Review Journal rather than a midwifery or nursing journal as it carried with it the potential to reach the wider audience of health service administrators, midwifery and nursing regulators and tertiary education service providers.

Following the publication of the paper the journal's editor received a letter from one of the Nurses Boards raising concerns about some perceived inaccuracies contained therein. This letter was forwarded to the authors and was much appreciated. Receipt of this letter confirmed that our decision was correct and that regulatory authorities had indeed read the paper.

In the publication we had emphasised the fact the Boards had a role to play in educating the public to understand regulation and that this role should be taken seriously. We also challenged the current status quo through asserting the importance of a need for change in the view and legal positioning of the Australian Nursing Council and all Nurses Boards regarding the identification of midwifery as distinct from nursing.

The letter is reproduced on the following page.

3.2.5. Letter to the Editor of Australian Health Review Journal

Australian Health Review [Vol. 25 n No 3] 2002 p185

LETTER TO THE EDITOR

Australian Midwifery Regulation in the Northern Territory

30 January 2002

Dear Editor,

The article on Australian midwifery regulation by Pat Brodie and Lesley Barclay (AHR, Vol. 24 no 4 2001) was brought to the attention of the Nursing Board of the Northern Territory. Members of the Board were alarmed by a number of factual inaccuracies reported in the article and the fact that this article was able to be accepted for publication with so many inaccuracies.

Legislation

A new nursing act was enacted in the Northern Territory in October 1999. Surprisingly, the article in the Australian Health Review refers to the old nursing legislation (*Nurses Act 1984*). This legislation was repealed when the new act was passed.

Australian College of Midwifery Incorporated (ACMI) competency standards

The Nursing Board of the Northern Territory endorsed and adopted the Australian College of Midwives Competency Standards for Midwives in 1998, making it one of the first nurse regulatory authorities to do so.

The article stated that only three nurse regulatory authorities had in fact adopted the competency standards. This is clearly incorrect.

Following the adoption of the competency standards they have been used to form the basis for the development of midwifery programs in the Northern Territory. The competency standards are also used when midwives seek to re-enter the profession after a period of non-registration. The midwife must be assessed as competent against the competency standards prior to the Board issuing a practising certificate.

Also since the introduction of the *Nursing Act 1999*, all midwives in the Northern Territory have been required to complete a self-declaration of their competence to practise midwifery and to declare that they practise in accordance with the ACMI competency standards prior to being issued with a practising certificate. Again the article incorrectly states that a self-declaration of competence is only required in Tasmania and Queensland.

Members of the Board are most concerned that at no time did the authors contact a member of the Board or the Board's professional staff seeking clarification on any matters in relation to the legislation, the competency standards or declarations of competency. A simple phone call would have provided accurate information. The article, as published, presents grossly inaccurate information, refers to non-existent legislation and certainly does not present a true picture of contemporary midwifery regulation in the Northern Territory.

Yours sincerely

Sandra Smiles
Chair, Nursing Board of the Northern Territory

Reference

Brodie P and Barclay L 2001, Contemporary issues in Australian midwifery regulation, *Australian Health Review*, Vol. 24 no 4, pp103-18.

3.2.6 Response to the Challenge

Following receipt of this letter we returned to our original sources of data and examined the methodology. The approach we had used was to access each of the eight statutes electronically and download them from The *Australasian Legal Information Institute (AustLII)* Database. This database is one of the largest sources of legal materials on the World Wide Web. This site provides free Internet access to Australian legal materials. The publisher's stated broad public policy agenda is to improve access to justice through better access to information for the public. *AustLII* publishes publicly accessible legal information, that is: primary legal materials (legislation, treaties and decisions of courts and tribunals); and secondary legal materials created by public bodies for purposes of public access (law reform and royal commission reports for example). It was this aspect of providing 'access' to the public that prompted us to use the database for the study in the first place. We hypothesised that there is confusion about the role of the midwife with a lack of consistency that challenges the legitimacy of the current Acts and their capacity to protect the public. Furthermore, any member of the public should be able to access a publicly available and readily accessible data source, such as the *AustLII* legal database and determine for himself or herself the role of the midwife in Australia.

We had also consulted with a nurse-lawyer, who advocated our choice of data source. Throughout the study, we continued to verify with her a number of inconsistencies and anomalies identified in our early analysis, further strengthening the validity and strength of the findings.

Upon receipt of this challenge we proceeded to review the more recently published Northern Territory Nursing Act 1999 and repeated the analysis. As the following letter explains we analysed the 1999 Act and regulations to determine their adequacy in regulating the education and practice of midwifery, drawing on the most recently published legislation in *AustLII* Database. Despite new legislation and claims otherwise, our analysis remained essentially the same.

This challenge served to strengthen our original claims, that there was confusion about the role of the midwife and a lack of consistency and standards within regulation. Despite reviewing their legislation more recently than any other state, the new Northern Territory Nursing Act 1999 states that its purpose is to: '*provide for the registration and enrolment of nurses and the regulation of the practice of nursing and for related purposes*'. Further, within the new Act midwifery continues to be defined as '*a restricted practice area of nursing*'. As such, our original findings,

which claimed that midwifery remained 'invisible' in a legal sense in Australia, including in the Northern Territory, could be sustained.

We provided this information in our response to the editor of the Australian Health Review Journal, which was published in the subsequent edition of the journal. The letter is provided in the following pages. No further communication was received after the response was forwarded.

3.2.7 Authors' response to the 'Letter to the Editor'

Australian Health Review [Vol. 25 o No 4] 2002 198 - 199

Letter to The Editor

Midwifery Regulation in the Northern Territory

20 February 2002

We write in response to a letter from the Chair of the Nursing Board of Northern Territory that was published in Issue 25 number 3 of the AHR, in respect to our paper on midwifery regulation that was published in Issue 24 number 4. The Chair of the Nursing Board raised three matters, and we will cover them in turn below.

Issue 1: our use of out-of-date information

The Northern Territory Nursing Board has a right to be concerned with our citing of out of date legislation if indeed this was the case. We conducted the data collection and analysis during May - June 2000 at which time the primary data source 'Australian Legal Information Database' cited the Nurses Act 1984 as the current legislation for nursing and midwifery in the Northern Territory. We did not check for any updated legislation on this location before submitting the paper for publication, nor was it foreshadowed there. We extend our apologies the Northern Territory Nurses Board for this omission, but the terms within which the research was conducted were clear. Perhaps we could have been specific in the limitations section that any recently updated regulations could not be identified.

Upon discovering the omission we proceeded to review the more recent Northern Territory Nursing Act 1999 and repeat the analysis. In keeping with the original aim of the research, we analysed the new Act and regulations to determine their adequacy in regulating the education and practice of midwifery. We drew upon the legislation that was current on 1 February 2002 in the Australian Legal Information Database - that is, the Northern Territory Nursing Act 1999 and the Nursing Regulations 1989.

It appears that, in spite of new legislation in the Northern Territory, our analysis remains essentially the same.

As in most states and territories across Australia, there is confusion about the role of the midwife and a lack of consistency and standards within regulation that places Australian midwifery out of step with most other western countries. Discrepancies in the standards of midwifery education and practice regulation nationally are evident and this limits the capacity of the current Acts to protect the public.

The long title of the Northern Territory Nursing Act 1999 states that it is: *'to provide for the registration and enrolment of nurses and the regulation of the practice of nursing and for related purposes'*. Further, within the new Act midwifery continues to be defined as 'a restricted practice area of nursing'. Such nomenclature has serious implications for the regulation of midwives who have never been nurses and who would not ever seek to hold themselves out as nurses. Increasing numbers of 'direct entry' midwives are now entering Australia from countries such as England, New Zealand and Canada. In addition, there are several Universities across Australia about to embark on three-year Bachelor of Midwifery degree programs. Under mutual recognition, these midwives should have no barrier to registering in any state in Australia as midwives, not nurses or (as stated in the Northern Territory Nursing Act 1999) 'midwifery nurses'. Under current legislation, the Northern Territory Nursing Board and several others will be challenged to accommodate these graduates. In a climate of severe midwifery workforce shortages our paper was designed to raise concern and debate about these issues. We intended to highlight the need for national consistency in the regulatory framework for midwives that clearly identifies midwifery and enables the necessary health services reform to occur in a manner that both protects the public and enables the appropriate education of the profession.

Issue 2: Competency Standards

The letter suggests that our paper is incorrect in its reference to the non-adoption of the Australian College of Midwives Inc. (ACMI) competency standards by the Board in the Northern Territory. We have returned to our original data source (the ACMI National office) to clarify the information that we received in June 2000. Indeed, as you point out, the ACMI Competencies have been endorsed and utilised by the Board since 1998. Confusion had arisen within the ACMI with documentation cited from October 2000, which refers to the Board's decision not to endorse the 'Validation of the Midwifery Competencies Report'. Nomenclature and language is confusing in the communication on this matter by stating that a nurse 'must declare competence to practice in midwifery' and also that he/she must use the 'ACMI beginner competencies'. Neither the researchers nor the ACMI are able to identify any document so titled. Nonetheless the Table 3 on page 113 of the article should be amended to reflect the correct status of the Northern Territory with regard to annual declaration of competency.

Issue 3: Contact with the Nursing Board

The letter reports the Board's concern that at no time did the researchers contact a member of the Board or the Board's professional staff for clarification on any matters relating to the legislation. As we identify in our paper, the design of the study was such that we analysed the documented legislation only, that is, the material available in the public domain. Indeed this was one of our underlying premises for the study. Our method was to conduct a systematic content analysis including a search for the basic attributes and common features found in most forms of professional regulation. Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. It was not our intention to interpret how legislation was enacted or what processes the Boards engages in during the course of implementation but rather to analyse the documented Acts and legislation as they are available in the public domain. We trust that this addresses your concerns and thank you clarifying the information with regard to the Nursing Act 1999 in the Northern Territory.

Yours sincerely,

Pat Brodie, Senior Research Midwife, Australian Midwifery Action Project.

Lesley Barclay, Professor and Director, Centre for Family Health and Midwifery, University of Technology Sydney.

3.2.8 Conclusion

The outcomes of this study highlight the need for (NHMRC, 1998b; Commonwealth Department of Health and Aged Care, 1999; NSW Health Department, 2000b; NHMRC, 1998b) national consistency in the regulatory framework for Australian midwives. This framework must clearly identify midwifery and enable the necessary health services reform to occur in a manner that both protects the public and ensures appropriate education of the profession.

This analysis of midwifery regulation demonstrated a number of serious inadequacies and inconsistencies that should raise concerns about both the standards of regulation, and the lack of clear recognition of midwifery in Australia. As has been shown, in every state and territory in Australia, midwifery is seen as part of nursing and is therefore regulated through Nurses' Acts. Recognition, status and visibility within regulation are arguably, the foundations upon which a profession

is built and assessed. Minimum standards of practice and regulation of the profession are integral to ensuring protection of the public. Without these essentials in place within regulation, Australian midwives will continue to struggle to maintain their capacity to contribute to effective maternity service provision.

Given the findings of this analysis, and in association with the results of the 'Midwives Voices Study', I felt compelled to examine the concept of midwifery invisibility as it is experienced in practice, organisational development and in policy formation. In the following section of the portfolio, through a series of case studies, I explore how leadership was used as a strategy to make midwifery visible and enhance the contribution that midwives make to maternity service provision.

3.3 STUDY THREE - LEADERSHIP AND COLLABORATION

3.3.1 Introduction

The third study complements the previous two in confirming the problem of midwifery's invisibility. Through the use of case studies I identify the problem as it was experienced in practice across three separate settings. In these case studies I explore my own, and others' attempts at providing leadership, to increase the recognition and contribution of midwives in maternity service provision. The case studies are used to explore observations and experiences of different methods, attributes and contexts for midwifery leadership and collaboration in maternity care, across a range of different organisational contexts.

The objective of these case studies is to investigate how midwifery leadership and collaboration can assist to overcome some of the barriers and contribute to the achievement of the necessary reforms in maternity care.

Different levels of health services have been chosen for investigation where midwifery leadership has been a critical factor in the development of maternity care. The different 'levels' or 'spheres of influence' all focus on the introduction of midwifery models of care, increasing the visibility, recognition and utilisation of midwives' skills and the use of evidence to support the strategic improvement of maternity services. Presented as three separate 'stories', they represent a widening scope of experience and influence that I have been involved in over many years.

Each case describes the different context and presents a reflective analysis of leadership. My personal historical reflections are informed by and draw on a fastidious capacity to file and keep track of personal records and memorabilia such as newspaper clippings, letters of thanks, photos of significant events, personal correspondence, and publicly accessible health department reports and policies. This collection of materials extends over a period of more than twenty years.

The first case study explores my personal story of leading change in the clinical practice setting. It links into an exploration in case two, of my experience of providing technical advice to organisations seeking to introduce changes to their maternity services. The experience of working as a midwifery adviser to a state health department, developing policy and a strategic direction for maternity services, is the subject of case three. All of the studies involve attempts at making midwifery more visible and recognised, through the use of a strategy of leadership.

The work draws on experience from the clinical field and data from across different settings. Through various roles, I observed or provided leadership and engaged with others in developing collaborative approaches to bringing midwifery forward as a visible contributor to maternity services. The section begins with a descriptive review of attempts to develop services and reform clinical practice. In particular the introduction of midwifery models of care is examined. The case studies then move through a number of broader organisational and policy contexts where attempts were being made by leaders to increase the contribution and visibility of midwifery.

Through these experiences, a number of critical aspects of leadership as a strategy to raise the professional capital of midwifery emerged. The need for analysis of these aspects and why they are important in the achievement of change in maternity service provision are the focus.

The case studies are underpinned by an assumption that emerges from clinical practice and experience. That is, that competent, well-informed midwifery leadership is needed for effective collaboration, which is required for the necessary changes to occur. The case studies focus on different contexts for leadership, essentially these are the different 'levels' or boundaries of health services leadership: clinical, organisational and policy. Within a milieu of widespread policy change and push for systems level reform, midwifery's contribution and capacity to influence change is analysed by examining the leadership of those who either facilitated, or at times, blocked change.

This analysis helps to further explain the barriers to midwifery that exist despite sound evidence and rationale for their removal. The concept of leadership as a strategy to overcome these barriers will be further developed from these case studies. This may explain why changes to policy are potentially straightforward and yet implementing changes at service provision level are so much more difficult, if not impossible, to achieve in some circumstances.

The potential to develop professional capital in midwifery, through a strategy of leadership that makes midwifery visible, and the development of new models of care is explored. It will be shown that enhanced professional capital and greater visibility may assist in making midwifery clearly recognised and able to contribute more fully to effective maternity services in Australia.

3.3.2 Context

Changes to maternity services policy, structures, processes and outcomes have been recommended through state, national and international reports and recommendations as well as the scientific literature for more than ten years. This has been reported earlier in the portfolio. Evidence of widespread adoption of these policies or implementation of the recommendations, however has been almost non-existent due to a number of barriers. Some of these barriers have been revealed in the 'Midwives Voices Study' and in the examination of the regulations governing midwifery in Australia, as reported previously.

Over the past two and a half decades, the organisation of and context for, the provision of maternity services in Australia has been changing. As discussed earlier, major shifts in government policy direction (NHMRC, 1996; NHMRC, 1998b; Shearman, 1989; Victorian Department of Health, 1990) and various reforms across maternity care provision including models and settings for care has been recommended. Theoretically at least, the promotion of 'midwifery led' care to improve continuity of care across all stages of pregnancy, birth and postnatal, has become increasingly evident (NSW Health Department, 2000b; Commonwealth Department of Health and Aged Care, 1999; NSW Health Department, 1996). This is described in detail in the introduction of the portfolio.

As such, innovative new models of care are beginning to emerge that require midwives to work in flexible patterns, with working conditions that reflect greater professional autonomy, and self regulation of practice including increased skills in referral, consultation and collaboration (NHMRC, 1996);(NHMRC, 1998b) (NSW Health Department, 2000b).

3.3.3 Rationale for studying leadership in midwifery and maternity services

The need to understand the nature of leadership and collaboration within the complexity of contemporary maternity service development is self-evident. Internationally, as stated earlier, within westernised health systems, there are concerns regarding increasing medicalisation, intervention rates and litigation in pregnancy and childbirth care. This is reinforced by suggestions that the benefits of modern obstetric care may be being overshadowed by its harm (Grant, 2000). At the same time, virtually all health service planning and policy reports relating to maternity services have recommended a greater role for midwives through the development of new models of care and increased recognition of their skills (NHMRC, 1996;

NHMRC, 1998b; Commonwealth Department of Health and Aged Care, 1999). This situation thrust the two key professional groups of maternity care providers – midwives and obstetricians, into the foreground of strategic policy and new service development and delivery, during a period of significant change.

3.3.4 Literature Review

There is a paucity of published research, discussion or exploration about how the relationships between midwives and doctors might be linked to improving the outcomes of maternity care (Leap, 1997). In the year 2000 the subject of relationships between nurses and doctors was the focus a special supplement in the British Medical Journal (Salvage and Smith, 2000; Zwarenstein and Reeves, 2000; Davies, 2000; Doyal and Cameron, 2000). In August 2001, Louise Barbour published a critique of a document produced jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives in the UK (Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 1999, Barbour, 2001) that outlined recommendations for changes designed to optimise safety in the organisation of care in labour wards. However, it is evident that the majority of the recommendations focus on increasing obstetric staffing levels and reinforcing the power and authority of the medical profession (Barbour, 2001). These reports also appear to reinforce the gendered division of labour in the health care setting (Lay, 2000; Pringle, 1998a). In examining these issues the author highlights the need for greater insight into the current inter-occupational relationship between obstetricians and midwives and its implications for the future development of midwifery and maternity services (Barbour, 2001).

A similar report was released in Australia following an inquiry into services provided at a major tertiary maternity unit (Douglas, Robinson, Fahy, 2001). Recommendations from this report were very similar with regard to increasing obstetric staffing levels and reinforcing medical authority and control over clinical decision-making, with little explicit reference to the need to increase collaboration and improve processes and systems of inter-disciplinary working.

In 2003, the emergence of a new role for nurses was the subject of a discussion paper examining the nature of collaborative practice between GPs and practice nurses in Australia (Patterson and McMurray, 2003). The authors sought to examine what hinders and what facilitates inter-disciplinary functioning within the Australian health care context. Such a review was timely as the Commonwealth government had just announced funding of \$A104.3 million dollars over four years for Divisions

of General Practice to employ nurses to address medical workforce shortages, in particular in a number of rural and remotes areas (Commonwealth Department of Health and Aged Care, 2001). This discussion paper highlights the history role of the practice nurse in Australia, which has been primarily one of assistant to the doctor. This was designed to assist in the running of the practice and to increase the throughput of patients, primarily the elderly or those with chronic illness. Questions regarding the willingness of many doctors to accept autonomous nursing roles were raised. This is compounded by the reluctance of many nurses to take on a higher level of responsibility. According to these authors, there exists distinct 'generations' of nurses who are wedded to different sets of values and see little advantage in embracing the new 'professionalism' as proposed by the current nursing leaders (Patterson and McMurray, 2003). It is highly likely that the same assessments can be made of the midwifery profession in Australia at this time. It is evident that some will wish to move forward with new models of care and greater autonomy, whilst others will choose to remain 'invisible' within their particular role and practice setting. This was apparent in the 'Midwives Voices Study' described earlier, with reports of perceived reluctance to develop midwifery models of care and evidence based midwifery practice by some groups of midwives within the same organisation or clinical setting.

3.3.5 Methodology - case study research

Choice of case study method

As shown previously, contemporary midwifery systems and the organisation of maternity services in Australia are facing considerable challenges and wide-ranging change. In any setting, the introduction of change is complex and influences are subtle with many organisational, managerial and political factors and processes being involved, often simultaneously.

A mechanism was needed for examining these complex processes by which innovations, changes and research evidence are incorporated into the development of maternity services. Case study research is useful as it purports to help to answer the 'why' questions associated with the introduction of new practices, approaches and processes (Yin, 1993). This method was of particular value to highlight the 'development' potential for research to bring about improvement with systems (Pegram, 1999; Yin, 1993). As such, it provided a suitable methodology to study the barriers to midwifery and leadership as a strategy.

Case study research relies on multiple sources of evidence, with data converging in a triangulating fashion (Yin, 1994). I have a collection of detailed structured and unstructured data about a number of related groups, individuals and processes that arose from my practice within the 'systems' of midwifery and maternity services development over a period of twenty years. The three contrasting settings were chosen because they reflect the different levels of health care where leadership is required for change to occur. These contrasts assist in triangulation of data sources, not to confirm each other but rather to contribute their own original 'piece' to the analysis (Jick, 1983). Triangulation of multiple data sources assists in demonstrating rigour in analysis and validity of findings (Pegram, 1999; Stake, 1994).

Of particular challenge in case study research is the need to ensure representativeness of the case studies chosen. As Hamel et al (1993) describe, cases must be chosen on the basis of being illustrative or revelatory. In some contexts, the rationale for their selection may be that they represent a unique opportunity, not normally accessible to researchers (Hamel, Dufour, Fortin, 1993). In this study, such opportunity came about for two reasons. The first was because of the unique role that I had commenced within a research team conducting a national study about midwifery in Australia. The second was my experience in practice, developing, implementing and evaluating midwifery models of care within the public health system. My day-to-day work in these roles became both an opportunity and a rationale to question, explore and study the process of leadership in midwifery.

Descriptive case study method

The research literature is fraught with confusion as to whether case study research constitutes a design or a method. Yin (1994) defines case study research as an empirical inquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used (Yin, 1994). This is reinforced by Merriam (1988), who suggests that descriptive case study research is essential when 'variables are not easily identified, or are too embedded in the phenomenon to be extracted from the case' (Merriam, 1988). Descriptive case study research is most suitable when 'how' or 'why' questions are being posed (Stake, 1994) or when the researcher has little control over the events and the number of variables is large (Burns and Groves, 1997). The method provides an 'in-depth' description using multiple methods (quantitative or qualitative) to 'spotlight' the selected factors or propositions, as they are located in the particular context (Stake,

1994). Throughout the case studies, I identify the key factors of leadership and spotlight them for the reader to apply within the given context.

The terms 'case study', 'case study method' and 'case method' are used interchangeably in the literature and whilst definitions may vary, these approaches appear to share several common elements. In this paper, the concept of case study research as a 'comprehensive research strategy' (Yin, 1994) is adopted. The work incorporates a logical design, explicit and multiple approaches to data collection and analysis, and incorporation of the common elements. Several authors cite these common elements in case study research as:

- Describing a 'real' situation within a contemporary context;
- Being a single, in depth investigation with the single object defined as an individual, group, phenomenon, organisation or society;
- Using multiple methods of data collection; and
- Being undertaken at the descriptive, exploratory or explanatory level.

(Yin, 1993' Stake, 1994, Bryar, 1999)

In terms of theory forming, case study research is described as a 'bottom up' approach, whereby the researcher seeks to describe, and then move on to explain, a phenomenon (Stake, 1994). The aim is to explore the reality of practice, organisation and policy issues with regard to leadership in midwifery services, with a view to learning about the particular process, and also to derive 'theoretical indicators and understanding which may be applied to other settings' (Stake, 1994). Thus, understanding the 'process' and 'factors' in the barriers to midwifery development - the 'how' and 'why' of midwifery's place in the development of contemporary maternity services in Australia, will be enhanced by the development of a theory of leadership.

Subjectivity of the researcher

Qualitative research acknowledges the inter-relationship of the researcher and the processes under study, rather than trying to hide it. In her work in nursing research, Lipson (1991) describes how the self may be developed as a 'research instrument' through various reflective activities. In this doctorate, my subjectivity as a researcher was related both to my role as a midwife in practice, employed within some of the settings being studied, and also as a researcher, being both participant and observer. Thus, the influence of certain aspects of my self, whether it was

personality, professional role, reputation, knowledge or particular style, will be identified and acknowledged. Many researchers suggest that self awareness and conscious reflection are important in this process (Lipson, 1991; Patton, 1992; Bryar, 1999; Burns and Groves, 1997). In this work, I paid particular attention to the subtle but potentially powerful influences that I may have had in conducting a study of leadership in Australian midwifery. These influences include my professional status and standing in the midwifery profession and at state health department policy development level [as a leader]. This was experienced and expressed through a number of positive collaborative inter-professional relationships. At the time of the study, I was one of only a small number of leaders in midwifery. Similar relationships in the field of social research have been seen by Sandelowski (1993) and others as being fundamental to the research process, in that relationships between the researcher and those who are researched are both basic and important, because the nature of the work is dependent on frequent interaction (Sandelowski, 1993; Woods, 1997; Burns and Groves, 1997).

3.3.6 Data

Data sources

The case studies draw on a variety of data sources. Data included field notes made between 1999 and 2003 - the period of the AMAP project; diary entries, e-mail and written correspondence collected from early 1994 when I commenced a role setting up a new model of midwifery care; documentation relating to three technical consultancies and associated health service policies from 1995 to 2003; memorabilia in the form of photos, thank you cards, tape recordings of media interviews and newspaper clippings from 1984 to 2003 and government reports and papers published between 1989 and 2003. The latter were available in the public domain.

A review of the contemporary evidence and literature regarding the efficacy of midwifery models, including national policy documents, state-wide strategic direction reports and published data on the outcomes for midwifery models, provided the contemporary contextual basis to the study.

Data management and analysis

In case study research, there are no specific methods of data analysis (Hamel, Dufour, Fortin, 1993). In this study, qualitative data only was collected using an

historical autobiographical approach to review the entire collection of data sources and analyse them using thematic content analysis (Strauss A, 1987).

The process of constructing the study initially involved gathering all of the related data (reports, correspondence, file notes), developing a description or narrative about the case (Patton, 1992). The case study became a descriptive picture with details presented chronologically and thematically. Assembling data in chronological order allowed a demonstration of a clear decision or 'audit' trail and provided a developing account of changes over time (Woods, 1997; Knalf and Howard, 1984). Through this process, I gained insight into the unfolding story of the phenomenon being studied across different contexts (Koch, 1994).

I was mindful of some authors who warned against attempting to see, hear and participate in everything related to the case. I accepted this and adopted a selective approach to sampling data. This incorporated a period of data collection closely followed by a productive period of recording and reflection (Stake, 1994). Several authors also recommended that particular attention be paid to discovering when 'crucial times' occurred, sampling these as well as the 'routine times' (Yin, 1993; Burns and Groves, 1997). I remained mindful of this advice.

Stage 1 of the analysis involved thematic content analysis and 'pattern matching' of the data drawn from each of the three different settings, seeking preliminary formation of theoretical propositions and explanation building within each. This is referred to as a 'case analysis' (Patton, 1992). An added dimension to case study research is the opportunity to study the case over an extended period. By working across different settings, reflecting on a period in practice of over fifteen years, and combining this with experience gained across a focused three year period, I was able to develop a significant understanding of conditions and situations and how they evolved over time. For example, I was able to compare and contrast the leadership traits of a Director of Midwifery within a particular setting, identifying certain attributes and qualities and compare these with another Director of Midwifery in another setting.

Stage 2 of the analysis took the results of the analysis of stage one for one case and compared them with another in a cross case analysis. This process involved the identification of 'cross-case issues' (Yin, 1994; Stake, 1994). This process is valid since the purpose of the study was to synthesise lessons and themes from all cases, organise them around key topics in order to form a theoretical framework (Yin, 1994). Thus, having identified certain attributes of a leader I then compared

and contrasted them, within another setting or context, determining the interplay between traits and attributes across different environments and settings.

Stage 3 involved generalisations at the level of theory, with the 'issue' or 'phenomena' being the focus, rather than the individual cases themselves (Yin, 1993). In this way, the contextual factors and subtle interplay of persons and places were interpreted and analysed, in order to determine the key factors of leadership that could be generalised.

Generalisation of findings

The findings from this research regarding the role of leadership in the development of professional capital in midwifery will be tied to the specific situation and locality within Australian maternity care. This involves interpretation of the contemporary organisation of maternity services and development of health care policy, as observed within Australia. Whilst not necessarily generalisable to other populations per se, the theory, propositions and explanations may contribute enhanced understanding of how and why recognising the potential of midwifery, and increasing professional capital, is critical to developing maternity services of the future.

Case study research is aimed at generalising to theoretical propositions, not to populations (Yin, 1994). The case study does not represent a 'sample' and thus, my goal was to expand and generalise theories (analytic generalisations) not to enumerate frequencies (statistical generalisations) (Bryar, 1999; Yin, 1993). Other authors have argued that since the case study is strong in reality, they are 'down to earth' and attention holding, in harmony with the reader's own experience and thus provide a 'natural basis for generalisation' (Patton, 1992; Koch, 1994). Further, as Angen suggests, these findings may achieve validation through 'ethical' processes which result in readers becoming 'more sensitised or enlightened about' a particular subject because the research has been done (Angen, 2000).

The main research challenge in conducting this study came from constructing the case records (Patton, 1992) and gathering all of the related pieces of data. In addition, there were also a number of access and ethical issues to consider.

Access and ethical concerns

The difficulty in obtaining informed consent in qualitative studies is well documented. Some authors argue that truly informed consent is impossible in such studies because events in the field cannot be anticipated and researchers therefore cannot

inform participants what to expect (Knalf and Howard, 1984; Lincoln, 1995). Consent to utilise the experience gained in my role as a clinical leader and consultant was obtained, as far as was possible, from organisations, which were the subject of the case studies. Permission was granted on the basis that confidentiality and anonymity would be preserved and sensitivity would be ensured. It was determined unnecessary to return to places of employment of some ten or fifteen years ago, as data sources for this period arose from my own individual recollections, records and memorabilia. The case studies use an historical autobiographical approach to incorporate collective and reflective insights obtained from each experience. As such, no single department, health service, organisation or individual could be identified. Data sources for the case studies, including reports, correspondence, file notes, observational data and reflective journal notes, were stored securely in a protected file and only accessed by the researcher and supervisor.

Unless otherwise stated, confidentiality and anonymity of the personnel and the services involved was assured through de-identification and omission of names, titles and organisations.

Ethics permission was obtained from the Human Research and Ethics Committee of the University of Technology, Sydney and written permission received from the State government health department.

3.3.7 Case Study One – Leadership in Clinical Practice

Introduction

The first case provides an historical synthesis of my early experiences of practice leadership in midwifery and maternity services development. I describe the different contexts, strategies and characteristics of leadership that I have observed and experienced. My roles were primarily those of clinical manager, coordinator, head of a program and later, as a consultant in midwifery practice. Each role provided experiences of leadership in clinical practice. In particular, they involved the implementation of new models of care that purposely sought to increase the recognition and utilisation of midwifery skills and expertise.

Aim

The first case study describes direct clinical experiences of my own and others' leadership roles through early attempts to improve maternity services for women.

Method

The process of constructing the study initially involved gathering all of the related data (including diary entries written correspondence, newspaper clippings, photos and memorabilia) together in order to develop a description or narrative (Patton, 1992). All available qualitative data collected from mid 1984 to mid 1995, which spanned the period under study, were gathered and sorted into dates and particular 'eras' in my career. By reviewing the entire collection of data sources, and analysing these using thematic content analysis (Strauss, 1987), I was able to determine some broad categories, under which each of the pieces of data would 'fit'.

Through a process of conceptual formation and labelling using a 'bottom up' approach, I first described the collection of data and then moved on to explain the phenomenon or theme that emerged (Stake, 1994). This allowed the development of some theoretical indicators and understanding that was later applied to other settings (Stake, 1994). Thus, I was continually seeking to understand both the process [in this case, the leadership I was experiencing] and the specific factors that led to the identification of the theme or conceptual label (Knalf and Howard, 1984; Koch, 1994).

Results

Descriptive narratives were developed around the themes that emerged from reflecting on the data and recollecting the experience. Through the use of explanatory notes, the data relating to various aspects and causal arguments of the phenomena [of leadership] was highlighted. They are reported here, according to the conceptual labels attached to the causal factors that I identified. These became narratives to explain the particular 'catalyst' or 'vehicle' that either enabled or required leadership to occur, within the various situations.

A Local leadership versus institutional control

My initial 'consciousness' of leadership began in the early 1980s through the role of charge 'sister' in a semi-rural, fifteen-bed maternity unit. The setting was a small 'cottage' style maternity unit where midwives worked in collaboration with three general practitioner (GP) obstetricians to provide the majority of clinical care. These doctors trusted and respected the midwives and supported a philosophy of non-interventionist 'family centred' maternity care, that was consistent with my own style of practice. The unit enjoyed strong community support. Public events reported in the media that jointly involved the doctors, midwives and the women and families of the community, such as the 500th baby for the year, were common.

I was appointed because of my clinical expertise. Clinical experts were required due to the isolated nature of the unit. There was no doctor on site and hospital emergency theatre facilities were 15 minutes away. Medical support consisted of general practitioner obstetricians who provided anaesthetic and surgical procedures 'on call'. Along with a small autonomous group of midwives they were expected to make clinical decisions and confer and consult with specialists as needed.

This was an ideal environment to develop 'women-centred' care and autonomous midwifery practice. I was employed to manage the unit and work in a clinical role. I saw the potential to create an optimum environment for improved birthing, with a greater role for midwives. This was because of the high level of mutual respect between the medical practitioners and the midwives. The support for midwifery that emanated from the medical team and the unit's reputation for being well supported by the community, constituted an opportunity to make midwifery visible and to develop 'capital' amongst the midwives.

In the first 18 months of my appointment, the hospital executive leaders [nursing and medical] supported me to make changes and modify procedures in order to enhance

care for women and improve efficiency. This included the introduction of more flexible policies around number and timing of visitors and encouragement of women's choices around positions for active birthing. They also involved a respect for the increased autonomy and decision making assumed by the midwives. These changes were introduced after consultation with the Director of Nursing and the visiting medical staff, all of who supported what I was doing and recognised the improvements made.

During this time, several midwives from a nearby larger teaching hospital joined the staff, being drawn to work in an environment that supported women-centred care and leadership that supported midwifery autonomy. On reflection, practices quickly developed into what many policy reports recommended some twenty years later, as 'best practice'. For example, we developed information brochures to give to women at the time of booking in, acknowledging their choices and including flexible approaches to different birth positions, length of stay and the number of support people present in the birthing room.

Outcomes were excellent in comparison to equivocal units and women were satisfied. Job satisfaction and morale was high with almost zero staff turnover and very low levels of sick leave.

Subsequently, approximately eighteen months later, two visiting medical officer (VMO) specialist obstetricians were appointed to the hospital. They quickly took over control and responsibility for all maternity care and most of the clinical decision-making. Specialisation in obstetrics was seen by hospital management as 'progress' for the community, promising better standards for all and a strategy to ensure the survival of the small unit in the long term. Simultaneously, the autonomy and the practices of midwives became scrutinised by the VMOs. Common events such as women being encouraged to stay at home in the early stages of labour to await established labour were challenged as being unsafe. Evidence of the challenges to my leadership in supporting the midwives in providing safe practice can be seen in an abstract of correspondence from one of the obstetricians:

DR.
 M.B., B.S. (Surg.), M.R.C.O.G. (LOND.)
 F.R.A.C.O.G.
 OBSTETRICIAN & GYNAECOLOGIST

STREET
 N.S.W.

TEL.

Dictated: 24.4.85

Typed: 29th April 1985

Sister P Brody
 Sister-in-Charge Maternity Unit
 HOSPITAL

Dear Pat

I am writing to express concern at some of the current attitudes and management practices at the Maternity Unit.

I refer firstly to the fact that early admission of patients in labour appears to be no longer practiced, in fact it appears that patients are often even allowed home when they are already in labour if the labour is early. Recently a multipara with a history of a three and a half hour previous labour rang to request advice when she was in early irregular labour and was told to wait at home until her contractions were more regular! Surely this is an invitation to disaster. This patient was already 5 cms dilated by the time she arrived at the hospital and could have been more. Would a complication have arisen there would have been very little time to correct it.

Labour is a stress on both the mother and foetus. If the patient is at home we have no way of checking, for example, if the maternal blood pressure has risen to dangerous levels. Likewise we have no way of checking the foetal condition. This is of particular importance as a labour that "niggles" and does not establish well is to some extent inco-ordinate and this actually places more stress on the placental blood flow.

Particularly in the case of a labour that fails to establish, if the patient is not in hospital there is no opportunity to practice active management of labour where this may be indicated. Despite our busy bookings remains a small unit and variations in results from different techniques may not be evident or statistically significant. However when I worked as a senior house officer at , where there were 3000 confinements annually, the better co-ordinated labours and better results generally were very obvious in those patients in whom rupture of membranes was performed for "desultory labour".

continued...

The midwives worked together and supported me as their leader. Together we collaborated with the GPs who were also resisting the changes being introduced. We held after hours 'crisis meetings' to collaborate and develop strategies prior to meetings with hospital administrators and the VMOs. Further obstruction to my leadership style came from one of the newly appointed obstetricians and the Director of Nursing. They appeared fearful of losing control. Litigation in obstetrics in Australia was beginning to emerge as a significant issue and they saw the 'specialist' model for obstetrics as 'best practice'. The 'women centred' and community focused nature of this unit was not recognised or valued. A plan was developed to create a new unit much like the teaching hospital 15 km away, which had five times as many births and was categorised as a 'specialist' unit. It must be emphasised, that the opinions of the Director of Nursing and the Obstetric VMOs

were consistent with medical orthodoxy at the time. Concomitantly, women were increasingly resisting this move and government policy was beginning to respond to women's lobbying for changes to maternity care (NSW Health Department, 1989). Abstracts of letters at this time sent by a woman and her GP to the Medical Superintendent and which were copied to me and several other midwives, highlights this resistance and challenge being expressed by consumers:

19.2.86.

The Board of Directors,
Hospital,

Dear Chairman and Directors,

As a mother and an active member of three community organisations I have enjoyed supporting the Maternity Unit over a three year period - birthing two children, fundraising and visiting new mothers and babes.

I was proud of "our" Maternity Unit and have widely promoted its welcoming "cottage" atmosphere; on the whole very caring, friendly and efficient staff; progressive birthing and after-care practices; and family-oriented policies. Despite the inadequacies of the building, the staff and practices made it a much more attractive centre in which to give birth than any of the larger and better equipped, but very impersonal, hospitals in the Metropolitan area.

I find myself disillusioned, however, as a result of changing policies administered, I am led to believe, as a result of a *Staphylococcus aureus* outbreak towards the end of last year. The administration, in introducing the policies, is denying many women and families a joy in birthing and after-care to which a great number of families in the community had become accustomed. Whilst I can appreciate the responsibility felt by the Maternity Unit administration and/or the committee which evaluated the Staph outbreak, I question their judgement in implementing measures which:

1. limit the support to labouring women to one person;
2. deny access of siblings to labour rooms;
3. enforce routine use of sterile drapes;
4. limit siblings to one nurse of the baby during the hospital stay;
5. require partners (during labour) and siblings to wear hospital gowns and "booties" during contact with their baby;
6. restrict visiting hours;
7. compel mothers to take babies to the nursery during visiting hours and night-time;
8. restrict access of visitors to the baby.

Although I realise that *Staphylococcus aureus* may present serious problems in hospital, I fail to see how the recurrence or spread of an infection which is predominantly harboured in the nose, throat and intestinal tract can effectively be prevented by the wearing of gowns (not sterile) and "booties". Placing babies in close contact in a jam-packed nursery with nursing staff handling a succession of babies would only seem to increase the chance of infection spreading. In view of the inadequacies of the

The Maternity Unit was cherished by the community and had the support of the specialist paediatrician and the GPs. Despite strong support for the preservation of the service, and my pleading with the hospital executives and nursing management of the hospital, the obstetricians held firm. Letters of protest from consumers did little to deter this 'progress'. In another letter from this period, abstracted from my personal files, one consumer wrote:

I have been monitoring the Board's progress in lobbying for a new Maternity Unit and simultaneously listening to community attitudes. The opinion of many in the community seems to be that the practicality of having a new larger unit close to operating theatres and pathology makes resiting the Maternity Unit desirable, provided the "homely" and welcoming atmosphere which has generated, particularly over the last few years, is maintained. I feel, however, that the recent policy changes may destroy this atmosphere and therefore jeopardise community support of the disaffected. I and many of my friends are currently expressing is indicative of community feeling.

The community of the Shire are very proud of their place in history, but will not be proud of hospital practices which take us back in history to when maternity patients were considered 'sick', husbands a nuisance and siblings and visitors to be barely tolerated.

Let's have our Maternity Unit back, fulfilling the community's expectations of a joyous birthing experience.

Yours faithfully,

A.J.

Mrs A. [unclear]

Ultimately, the situation became untenable for me, essentially because of a conflict in philosophy and style of practice and barriers to my leadership. I left the unit after three years as the manager. The entrenched position of power and authority that the Obstetrician held was a barrier to any possible development or service innovation. As the midwifery leader, I 'clashed' head on both with the head obstetrician and with the Director of Nursing. Soon after my departure, four other experienced midwives also left, the 'specialist' model of care prevailed, and the small cottage unit was closed in favour of demountable buildings in the grounds of the main hospital. Within two years of this move, all GPs had ceased their obstetric practice.

Disillusioned, I withdrew from full time salaried employment and worked independently as a self-employed midwife, providing home births and community based childbirth classes in the Blue Mountains, west of Sydney. I reflected on my experience and drew strength and increased confidence from the women whom I saw giving birth in their own way, in their own environment, supported by family and friends. I knew that midwifery made a difference to women's lives. The experiences were not very different from many that we had provided in the cottage maternity unit, prior to its reassignment into obstetric specialisation. Many of the women, for whom I was now midwife, had previously given birth in that unit. The GPs referred some of them in the hope that they might achieve the birth of their choice by staying at home with a midwife whom they knew. This was a period of personal reflection and learning. I spent a lot of time contemplating my role as a midwife, seeking to better understand how to lead and create change, and where best to put my skills and energy in the future.

I resumed full time salaried employment about eight months later, taking up a position as a midwife in another small district hospital. I resolved, that I did not want to remain outside the 'system' as an independent practitioner in the long term, rather I felt renewed energy to return and try to change the system from within! I felt strongly that women deserved a choice of care that suited them, and that if midwifery was recognised as effective, women's overall experiences could be improved. It was becoming evident that skilled leadership from midwives was necessary to achieve wide spread system change. I continued for some years to provide care to a small number of women choosing to give birth at home. This sustained me at a personal level, constantly affirming my belief in the powerful benefits of a woman experiencing normal labour and birth.

B. Education and knowledge for leadership

In 1988, I enrolled in a Bachelor of Nursing (Health Sciences) at a university that promoted 'primary health care' as their theoretical framework. From what I had read, this seemed, philosophically at least, to be the most appropriate basis upon which I could further develop my education and knowledge. I knew that if I was going to meet the challenges of working within the system, I would need more education, as well as the increased authority that comes with tertiary qualifications. The knowledge I gained prepared me well in the foundations of 'primary health care' (Wass, 1994) and, in particular in the importance of positive discrimination, social justice and self-determination (World Health Organisation, 1978). These theories and principles have continued to inform and direct much of my subsequent work and thinking, both as a midwife in practice, and through various roles as a leader and a teacher.

In the late 1980s, I was appointed manager of a large postnatal ward in an urban obstetric tertiary referral hospital. This role provided me with the opportunity to learn more about management and leadership, 'within the system'. I had the privilege of working with an excellent divisional leader who had a psychiatric nursing background. She demonstrated excellent communication and negotiation skills, inspired self-confidence, autonomy and self-responsibility amongst the staff, and sought to help us all grow professionally and personally. Through her leadership, we developed and became united, supportive of each other, open to new ideas and primarily concerned with the needs of women and babies in our care. Her 'leadership philosophy' exemplified in all of her behaviours and actions, motivated us and pervaded all of our activities. This contributed to a new organisational culture amongst the midwifery leaders of the maternity services.

Change was embraced whenever it related to better care for our 'clients'. Increasing the visibility of midwifery and recognising the role of the midwife, were acclaimed as key professional development strategies. Whenever nursing was discussed, inevitably the words 'and midwifery' would be inserted into the discussions or documents. My personal belief in midwifery as a powerful agent for change in maternity care was renewed, supported and encouraged by her leadership. With her encouragement and in association with my own developing education and professional growth, I began to give seminars and workshops, speaking publicly about the importance and the potential of midwifery.

The culture of recognising and putting a more positive emphasis on midwifery visibility and leadership appeared to enhance the confidence and self-worth of midwives and the hospital became somewhat like a 'magnet' (McKee, Rafferty, Aiken, 1997) to other midwives wishing to work in such a workplace culture. Morale and confidence was high and midwives exemplified this for example, in assuming a stronger role in challenging outdated practices. Simple examples of this included support for the woman who wanted to leave hospital earlier than 'usual', to refuse routine complimentary feeding of her newborn baby, or to resist the offer of induction of labour, when pregnancy was prolonged. Midwifery was being made more visible through midwives and women being informed and knowledgeable.

At this time, I started to understand that through education, good leadership develops other leaders as well as the quality of the service and the workforce. It was an exciting time, which on reflection was a very rich opportunity for learning and acquiring the knowledge that was necessary to challenge and change organisational systems, cultures and structures.

C. Organisational change through leadership

These local changes in the organisational culture of maternity care in our unit were occurring at the same time as the release of the state-wide ministerial review of maternity services, known as 'The Shearman Report' (NSW Health Department, 1989). This was the result of extensive consumer lobbying and much of what was recommended related to the need to move away from increasing medicalised birth and maternity care. These changes were strongly supported by state-wide Women's Health Service Coordinators. These roles [Women's Health Service Coordinators] were integral to advocate changes and implementation of health department recommendations for reform in maternity care. The report recommended many

changes that were designed to improve choices for women and increase the utilisation [and recognition] of midwives.

One particular recommendation was for the piloting of a continuity of midwifery care scheme, shown to be beneficial in Britain - the 'Know your midwife' scheme (Flint, Poulengeris, Grant, 1989). Seeing this as an opportunity, I joined with several other midwives, our divisional midwifery leader and the local Women's Health Coordinator to prepare a submission for funding for such a scheme in our unit. We sought endorsement from the head of Obstetrics of the hospital but this was not forthcoming. Nonetheless, in 1989 the submission was sent to the Women's Health Unit of the Commonwealth Department of Health under the auspices of our midwifery service, with the full support of the hospital executive. Introducing a scheme such as this was seen as the next step in developing greater visibility and recognition of midwifery models of care and the associated improved outcomes for women. This would build on the already effective 'Domiciliary Midwifery Program' (having changed its name from 'Obstetric Early Discharge Scheme' to include 'midwifery') and a successful 'Midwives' Clinic' for low-risk women (Giles, Collins, Ong, MacDonald, 1992).

Despite repeated requests for feedback from the Women's Health Unit about our proposal, there was no evidence of any funding being made available. I left the position of manager of the postnatal ward the following year, to search for a role that would enable me to initiate development of comprehensive 'primary health care' maternity services (Brodie, 1993), in particular, community midwifery. I believed that continuity of care was important to women, and also to the future integrity [and possibly the viability] of the role of the midwife. I also saw the consequences of lack of continuity of care with poor decision-making and negative outcomes for women, and continual fragmentation of the midwifery role.

Throughout this period, as I continued my own professional education, I was sure that strong leadership could assist in changing the system of maternity care. I knew that midwifery leadership was important in addressing the trend towards medicalised childbirth and maternity services which failed to recognise [and in some cases subordinated] midwifery (Willis, 1983). Within the system at this time, there was very little continuity of care and relationships could not be built or sustained with women. I envisaged the potential benefits that could ensue from women knowing their midwife and from midwives feeling more involved and trusted, within systems of care that utilised midwives' skills and enhanced their confidence, self-concept and

capacity to collaborate. My education at this time led me to read more and reflect on the midwifery literature from around the world, particularly that related to the benefits of continuity of midwifery care. I was inspired by the work of several midwifery leaders in the UK and New Zealand.

Having been a member of the midwifery professional association since 1979, I began to get more actively involved in political and professional midwifery work. I began to attend Executive meetings of the midwives' association and the various conference presentations and seminars for midwives. Some of the influences and outcomes of these activities are described later in the portfolio in Section Two.

I changed roles again and took up a position of coordinator / manager to commission an area-wide maternity early discharge program, across three hospitals in an outer area of a large city. I saw this as a first step in developing the community's trust in midwives, as well an opportunity to show that midwives can work autonomously, safely and collaboratively outside of a hospital. Within this role I argued for a core service principle of equity of access so that all women could receive early discharge midwifery care in their home. Arguing from a primary health care basis (Wass, 1994) I strongly discouraged the planning committee from adopting strict selection criteria. This was because I knew that in this socially disadvantaged community, the very women who would leave hospital early would include many who were not identified as 'low risk' or 'appropriate'. Such women included those without social support or childcare and very young women who would not tolerate prolonged hospitalisation. At this time the criteria for suitability for early discharge in other centres included such essentials as 'a clean toilet and bathroom', 'hot running water' and 'adequate heating'. The presence of another adult was seen as an 'essential' measure of 'suitability' to leave hospital early. All of these measures were based on the first successful program in maternity early discharge in NSW that had been the subject of an evaluation (Palmer, 1986).

The advocacy and support provided from the Area Women's Health Coordinator and the inspirational leadership from the Area Director of Nursing enabled the steering committee to develop criteria, which were flexible, practical and appropriate for the community. We met repeatedly with obstetricians and paediatricians in order to reach consensus guidelines. These had to be determined separately for all three hospitals and between different groups of staff. As this was an Area-wide program they had to be consistent enough to allow for 'inter-area transfer' – a new concept in maternity early discharge programs at this time. Our selection criteria were seen as

'radical for the times' (Brodie, Cupitt, Cassidy, Goddard, 1992). There were some initial barriers and resistance to introducing early discharge programs from some individuals, most of whom were midwives who had practised in the same way for many years, or community nurses who felt that their area of professional practice may be under threat. These concerns were addressed and ultimately overcome by repeated meetings, reassurance, effective listening and respect for views and attitudes that were different from my own or those of the steering committee members.

Explanation, provision of information and data, presenting a positive image, promotion of midwifery and the 'early discharge' concept through the media, all served to reassure people that this was a step forward in modern maternity care.

Local newspapers ran the following articles:



When crises arose that could have set our efforts back, [for example a baby with a high level of jaundice having a delayed diagnosis and readmission to hospital], a meeting was convened and key stakeholders were drawn together to discuss, clarify, problem solve and communicate concerns. Processes of formal and informal communication were set up and all involved were encouraged to air their views, ideas and complaints. Quality improvement systems were put into place such as the review of protocols and practices and the regular surveying of women's views about the care received. As the service leader, I gave feedback both positive and negative, to the midwives on a regular basis. When higher level authority and leadership was

required, such as if I was having problems with a particular individual or group, the nursing director would address concerns and reiterate her support for the program and the principles that underpinned it. The director also provided me with advice, inspiration, ideas, resources and encouragement to sustain the effort of introducing and leading organisational change. Her personal support contributed to my self-confidence and belief that I could manage most of the difficult situations.

The Domiciliary Midwifery Program was well established and fully utilised across all three hospitals within two years. Outcomes were positive and with better than expected results when compared to some other programs (Brodie, Cupitt, Cassidy, Goddard, 1992). We sought positive publicity and promoted the program and the role of the midwife through local media outlets and asked local women, as users of the service, to evaluate and report their views. Midwifery care provided out of hospital became commonplace and recognition of the role of the midwife increased. We changed the name very early on from 'Obstetric Early Discharge Program' (as per the evaluated pilot) to the 'Domiciliary Midwifery Program' (DMP). Making midwifery visible to the public and the professions was a deliberate strategy to increase the recognition of midwifery. The program continues today with a similar structure.

Following the success of the DMP, and still within the area consultancy role, I worked in collaboration with the Area women's health coordinator, an obstetrician and the manager of a non-government organisation youth health centre, to develop a community based outreach antenatal clinic for young pregnant women in a specific area of social deprivation. This was another recommendation of The Shearman Report (Shearman, 1989). Working through a consultative processes and 'primary health care' approach, we developed an antenatal clinic within a youth health centre in a suburban shopping precinct. Within weeks of starting the clinic it became the main antenatal clinic for young women in this area. Most of the young women preferred the non-hospital environment and relaxed approach of the midwife and the obstetrician in a community setting. Collaboration and a degree of mutual trust between these two health providers enabled all young women to attend regardless of any risk factors. The respect for the skills of the midwife shown by the obstetrician, and the capacity of the midwife to refer and consult in a timely manner, ensured excellent care was provided. Outcomes for this clinic were comparable or improved to more traditional settings (Stacey, Raymond, Bevington, Wagner, Brodie, Jones, 1992; Hancock, 1999). The clinic continues today with the addition of continuity of midwifery care during labour being available for some women (Personal

Communication H Cooke 2003). Midwifery autonomy and leadership was recognised, understood and supported through this model, which was a significant organisational change for this hospital and most others in the country at the time. The young women and their partners recognised the role of the midwife and the primary health care approach contributed to a high level of uptake of the service. It was seen as an exemplar and was reported as such in a chapter for a textbook entitled: 'Promoting Health: a Primary Health Care Approach' (Brodie, 1994).

During this period I worked with the newly appointed staff specialist in obstetrics to create an Area-wide maternity services liaison committee, which was another recommendation from the Shearman Report (Shearman, 1989). We worked together to implement a collaborative committee that consisted of three Obstetricians, three senior midwives and three consumers. The focus of the committee was to develop area-wide maternity service plans and priorities and to be a forum for evaluation and review of quality and outcomes of care. This committee structure was innovative, being one of the first of its kind in Australia, and has continued to the present day.

My reflection on all of these activities and strategies that involved leadership processes to implement organisational change, led me to believe that it also necessary to have the right structures that permit leadership to occur in the first place. For example, the creation of specific roles such as coordinator, service leader or consultant, or constructing a committee that was representational, ensured projects or new services not only started well but also were also subsequently able to be sustained.

D. Leadership enabled by Government Policy

It was while I was in the role of area midwifery consultant, that I was notified that Commonwealth [Medicare Incentive] funding had been provided to trial a 'Know Your Midwife' (Flint, Poulengeris, Grant, 1989) scheme at the tertiary obstetric hospital from where we had earlier submitted the proposal some two years earlier. I saw this as a great opportunity to develop midwifery models of care in the public health system and to evaluate their effectiveness. In mid 1992 I was appointed to the position of coordinator / manager to set up and evaluate the 'Team Midwifery Project' over a three-year period. This involved responsibility for staff selection, development of criteria, protocols and standards, marketing and public relations associated with the project, day to day management of the team midwives and the budget, and collaboration with a research team to develop and conduct a

randomised controlled trial. This was the opportunity I had been seeking. I was given a position of legitimate authority through the support of my previous manager, the divisional nursing leader, who provided me with the autonomy and trust to lead the development of the program. I gathered the scientific evidence from literature and the state and federal policy documents that supported the introduction of the new model of maternity care. I then proceeded to initiate consultation and discussions with key stakeholders, such as midwives, managers, obstetricians, paediatricians and community health staff. Once again, on reflection, it was the structure that was created that permitted me to lead the developments and implement the changes necessary for the new model of care.

I also learnt that adequate time was essential to allow for a proper introduction of the project and to ensure its sustainability. I requested four months to do the preparatory groundwork, consultation and important relationship building that I knew would be critical and that I had learned from observing other leaders. 'Processes' became as important as 'structures' and 'outcomes'. The way I approached an individual and presented the subject became central to their willingness to engage in the initial discussion and ultimately the project itself. I needed to talk with midwifery managers, other midwives, women in the community, social workers, administrative personnel, community health staff, resident and registrar doctors and of course, consultant obstetricians and paediatricians. I framed the introduction of the new scheme as an exciting opportunity for our organisation to improve our systems of care and to introduce the changes that government policy was requiring.

The media articles that we produced reflected this strategy of promoting the good work of the hospital in supporting midwifery, as the following example shows:

Parramatta Advertiser, Wed 8 Dec 1993

Midwifery project gives new life to childbirth **Harrison** **arrives the** **easy way**

by NAN WEBBER

BEING part of Westmead Hospital's team midwifery project for the birth of her first child was the best decision Gemma Cragan ever made.

"The program is customer-focused," Gemma said. "I had active contact with the project midwives throughout my pregnancy, labor, birth and postnatal period at home."

"This continuity of care is not possible anywhere else."

Gemma and husband Anthony, who was with her during the labor and delivery, said it was a wonderful experience.

"We developed such trust and confidence in the midwives who, should there be any complications, work closely alongside the doctors," Gemma said.

"By supporting me and giving me informed choices I always felt I was in control. I wasn't stressed at all, and felt very calm."

Anthony agreed: "I was never scared and felt very confident of the midwives."

Gemma said the birth plan was discussed pre-empting any unexpected outcomes, preparing her psychologically, and later debriefing and counselling as well.

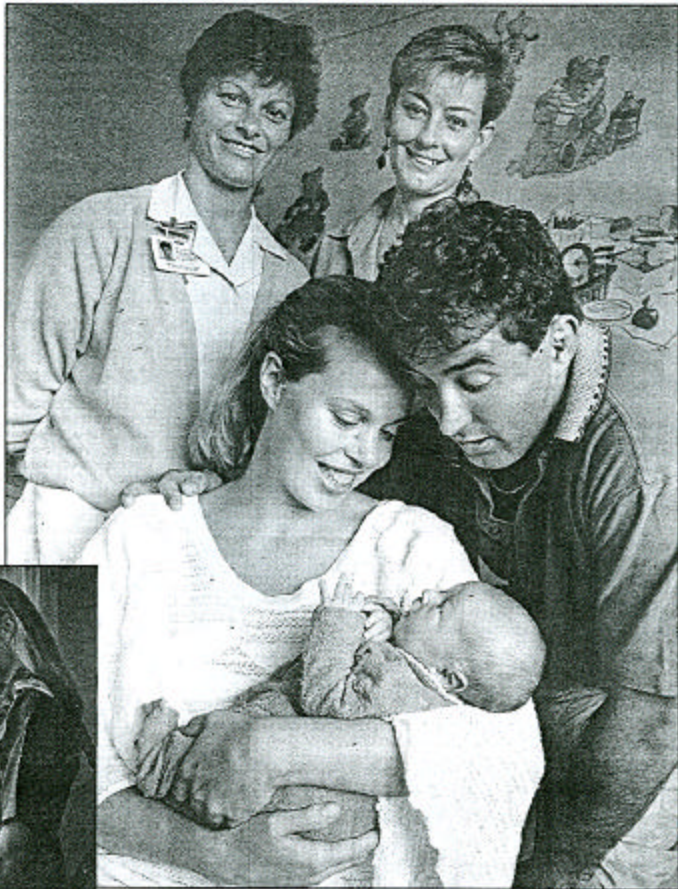
"I wasn't anxious or fearful, just confident and trusting," Gemma said. "I feel I'm off to a good start with my new life as a mother."

Gemma chose early release from hospital, two days after the birth of Harrison.

"The baby settled beautifully in his own environment and we're all very relaxed," she said. "The midwife has already visited me at home and checked on baby and me."

The midwifery project received its funding from the National Women's Health Strategy initiatives.

"It started in 1992 and ends next month."



Inset: Midwifery team project manager Pat Brodie says "soon" to pregnant Gemma Cragan. Above: Happy ending with midwives Beverley Robbins and Lynne Grace, who delivered Harrison, and proud parents Anthony and Gemma. PHOTOS Jeff Dormanin

Still going strong

IN last week's Advertiser we mentioned that the successful Team Midwifery Project would finish in January. Not true. The team is alive and well and continuing. The new service enables the mother-to-be to get to know a small number of midwives during her pregnancy. One of those midwives will look after her during labor and birth. After the baby is born she will be visited in the postnatal ward by the same midwives. Details Pat Brodie 633 7510.

The need to go slowly and to include everybody in the change was expressed openly to those with whom I consulted. This was paramount to the ultimate success of the program. We convened a working party and ensured key stakeholders were represented.

I sought the advice of a colleague, a midwifery leader who had commenced a similar program and an evaluation at another hospital in the previous year. We conferred on many issues and shared ideas about our work in creating organisational change and the challenges it presented. We supported and encouraged each other on a regular basis, talking as often as twice weekly over a two-year period. Her program was one year into its implementation and she was able to provide many useful ideas and

suggestions. We agreed that it was important that our models and the research design should be as similar as possible in order that we would be able to compare and contrast them at a later date. Unlike my situation, she was employed in a unit where medical support for the midwifery model had been established and was genuinely committed. Medical power and authority was not as entrenched and there was a genuine respect and trust of the midwives working in the new model. I learnt much from her including her skills of collaboration, determination and, critically the importance and value of using current scientific evidence and the drive to implement government policy, when negotiating with doctors.

As the program leader, the 'strategic position' that I chose was to promote the new model as a new and exciting way for midwives to work, namely that they would 'follow the woman' through her pregnancy, birth and postnatal experience. Although this was a significant organisational change and a potential threat to the control and authority of the medical hierarchy, I joined with others in being subtle and at times understated the potential of the new model.

Another important strategy was to say that, in so far as the medical care of the women was concerned, these aspects would stay the same. I chose this position in order to manage the opposition that I was experiencing from the head of the department of obstetrics. He had been heard to say that the program would never work and that he would never support it. The project was under the nursing and midwifery leadership of the division of the time and therefore the designation of responsibilities and working conditions for the midwives was not under the jurisdiction of the department of obstetrics. Again, the structure within the organisation was important in terms of reporting and accountability. The resolve and commitment to this fundamental principle by the midwifery divisional leader, coupled with respectful, clear, consistent information provided by her to the head of obstetrics, enabled the process of implementation to continue, almost unchallenged. This was despite covert and at times overt opposition. She provided a 'shield' that allowed us to continue with the planned organisational change, whilst the concerns of the medical director were heard and considered but not able to develop into complete barriers to the implementation of the midwifery model.

E. Research as strategic authority for leadership

At an individual level I had ongoing debates with the head of the department of obstetrics about the efficacy and cost implications of continuity of midwifery care and his supposition that it could not succeed in a tertiary setting. This debate became

heightened when negotiating an agreement about the selection of clients who could access the new program. His view was that only very low risk women should be eligible to participate, whilst I argued that if the model is to be of benefit then surely all women should be afforded the chance to access it. Fortunately, this principle was well supported within the steering committee for the project, which included a staff specialist obstetrician. The selection criteria remained broad to include almost all women, only excluding those who had extreme risk factors that were evident at booking. This was eventually agreed to on the grounds that it was for the purposes of research as well as a reflecting equity of access through primary health care principles (World Health Organisation, 1981).

Skilful negotiation and informed debate and discussion occurred during the project's steering committee meetings. The midwifery divisional director chaired these. She provided excellent leadership training as well as ensuring, at the outset, that all members of the steering committee adopted some core principles. As such, when individuals challenged selection criteria or other decisions, the committee had a clear process and framework on which to fall back on, avoiding any potential erosion or 'derailing' of the project. Again, this shows that 'structure' and 'process' and the particular skills and traits of the leader were significant.

During this time, I made a decision to pursue further academic studies and enrolled in a Masters of Nursing (MN) by research thesis. I spent more than a year searching for a suitable Masters of Midwifery (MM), rather than nursing, as I was resistant to the notion of having 'MN' as a qualification rather than 'MM'. All of my professional activities had related to promoting and developing midwifery. The decision to proceed with the 'MN' was ultimately based on the absence of a good quality Midwifery Masters anywhere in Australia at the time, and the positive features of the Masters of Nursing by research thesis. My interpretation was that this would enable me to develop further as a leader. The way the MN was being offered created for me the:

- Chance to join a team of like minded midwifery researchers who shared a vision for improving maternity care systems
- Opportunity to explore research and intellectual training and study with maximum freedom, creativity and flexibility
- Chance to critique and be challenged on my own work and assumptions about midwifery, maternity services development and leadership

- Opportunity to work academically with one of the few midwifery leaders in the country whilst gaining sound research training

I ultimately chose a midwifery leader as my academic supervisor because of the anticipated benefits and opportunities that I knew would flow from our association. Leadership, advocacy and political skills were some of the benefits that I acquired alongside this three-year process of developing research and scholarly skills and ultimately obtaining the Masters degree by research. I acquired those skills through watching and listening and engaging in discussion and debate that helped me clarify understanding and develop new knowledge about leadership. The subject of my research was the experiences of team midwives involved in the new team midwifery models that were being introduced at two hospitals, one of which was the hospital where I was employed.

The Team Midwifery Program became well established and continues today as a model of continuity of midwifery care available to approximately 10% of women booking at this hospital (Personal communication C. Adams 2003). As soon as the randomised controlled trial was completed, and despite good outcomes, high client satisfaction and cost efficiency (Kenny, Brodie, Eckermann, Hall, 1994), the Head of the Department of Obstetrics issued a directive that only low risk women could be offered the program. I attempted to address this in a number of ways. The challenge however was in recognising that, as the research phase was complete, he now had the authority to determine which clients could access the service. This was despite the results of the study that proved his decision could not be substantiated. This action was reminiscent of my work in the early 1980s and put me in a position that was frustrating and difficult. I felt powerless to affect a change to his directive. On reflection this was a clear case of him using his authority and power to ensure that we could not proceed with our innovative service as we had first developed it.

As the third year of the program commenced, and after consultation with the divisional midwifery leader, my role was broadened to 'Clinical Midwifery Consultant'. Over the next six months, I gradually handed over day-to-day responsibilities for management of the team midwives and expanded my area of leadership responsibilities across the maternity unit more broadly. This included staff education, professional development and mentoring activities, quality management and evaluation initiatives, small research projects and external consultancies to other services wishing to introduce midwifery models of care. I was responsible to lead practice change in midwifery and maternity care that incorporated the use of evidence. This was achieved through a gradual process of leading and engaging

midwives, educators and doctors in collaborative discussions and debates, protocol meetings and the distribution of journal articles and other resources. Several key management positions changed in this time and the new midwifery managers worked well as a team to further enhance the organisational culture towards a women-centred approach with increasing respect and recognition of midwifery skills by other nursing managers and hospital leaders. This was an enormous achievement in this particular unit, which had a reputation for being highly medicalised, given the leadership style of the head of the department of obstetrics.

Around this time, we also introduced a rotation program for all midwives to allow them to regain the range of midwifery skills rather than being focused in one clinical area only. The belief underlying this additional organisational change was that the role of the midwife was a comprehensive one that included all aspects of care of women through pregnancy, labour, birth and the postnatal period. If we were committed to greater midwifery visibility, recognition and development then we believed that we must promote access to the full range of midwifery practice for as many midwives as possible. This met with great resistance initially but with information, education, support and good leadership from the midwifery managers, the program soon accepted and incorporated as a key staff development strategy. (NHMRC, 1996).

In order to achieve the goal that most midwives would participate in the rotation program I was challenged to show strong and clear leadership as some resisted the change. I drew upon the skills I had learnt earlier in my career from midwifery leaders that related to introducing, managing and sustaining organisational change. On reflection, and drawing on their role modelling over several years, the skills that I sought to reproduce included:

- Provision of clear, consistent, easy to understand information and rationale
- A realistic timeframe that allows adequate time for people to process, adjust and prepare
- Willingness to listen to arguments against the idea and discuss them further
- Commitment to the vision with an awareness and willingness to change if intolerable complications ensue
- Capacity to manage minor fallout and move on
- Flexibility and a willingness to modify plans and approaches

- Awareness that 100% achievement of change is rare
- Establishment of a support team that included other leaders and managers who were committed to the same plan, goals and outcomes
- The rotation program was achieved within the time frame without major challenges and difficulties.

In reflecting on these experiences I learnt the importance of collaboration and building respect that, over time could lead to the development of trust. I also learnt how to deal with resistance and conflict and had a better understanding about structural barriers that no amount of knowledge or skill could change. For example, the role of the head of the department of obstetrics and his formal authority and position of power enabled him to have the ultimate say on clinical issues and final decisions about future service models. This was despite the success of what became a high profile service that others wished to replicate. The fact that we were able to introduce the model at all was largely because it was part of the new directions that government policies were recommending and that we had received funding to implement. Without that initiative driving it, the barriers put forward from the medical establishment would have ensured it would have never succeeded.

F. Readiness for Organisational Change

In mid 1996 I was invited to apply for a newly created position at another teaching hospital that was seeking to introduce midwifery models of care. I knew a little about this organisation, as in the year previous I had been a member of a consultant team reviewing the maternity services in that region. That review had recommended widespread reform and reorganisation to the area's three maternity services including the appointment of a Professor-Director of Obstetrics. This hospital had already embarked on a process of change to its organisational culture and was well advanced in its planning of innovations in maternity service provision. A consumer needs analysis had been completed and recommendations based on its findings were beginning to be implemented (Everitt, Barclay, Chapman, Hurst, Lupi, Wills, 1995). The midwifery leaders of this maternity unit, with the added bonus of having a new director of obstetrics that supported midwifery, were a cohesive group. They were committed to developing an organisational culture that was forward thinking and inclusive of changes in line with consumer needs, government recommendations and evidence. Central to their vision was greater consumer involvement and enhanced visibility and recognition of midwifery, in particular, through the creation of continuity of midwifery care models.

This was also the organisation at which my academic supervisor was based. The constellation of factors, namely progressive midwifery leadership, a supportive obstetric director, an environment of readiness to change, a clear vision for service development and an emerging research culture within maternity services, made this new role an excellent next career step for me. Here I could continue my professional endeavour of contributing to maternity systems reform within a supportive milieu. I had a strong belief that in the long term radical changes were possible in this service.

One of several reasons for this belief was the appointment of a number of key personnel to assist them in their strategy of change and developing improved services. These individuals included a staff specialist obstetrician who was, at least potentially, 'midwifery friendly' and a research midwife with substantial skills and vision for the new models of care. These individuals complemented a team of enthusiastic and dedicated midwives and midwifery leaders who had already commenced reform and reorganisation of the services. I was appointed to commission the development and implementation of the new models of care and to work with the research team to conduct a randomised controlled trial of the new model of care.

My work began immediately even though I was on a working holiday in Britain. I consulted and liaised via fax and phone with the research midwife who was setting up the trial. In consultation with a working group set up to manage the changes, we needed to decide on the criteria for selection of the women, the type of model and the specific outcomes to measure. There were several issues that required debate and negotiation and we worked well as a collaborative team even through fax and phone calls. Decisions regarding some issues were viewed as difficult and challenging, and were deferred for a later decision. For example, whether to include women with risk factors (such as previous caesarean section) in the study, and whether to base the antenatal clinics in a community setting rather than in the hospital. All members of the team listened to each other's concerns whilst debating the rationale for including them as important features of the new model.

A randomised controlled trial of the new model was conducted over a three-year period. During this time I was involved in the development and integration of the model into mainstream services. This included facilitating the clinical skills and professional development of the midwives whilst working alongside the lead researcher.

The process of organisational change in this service used research as a tool. The research framework in, and of itself, provided the structure, opportunity, formal authority as well as the rational basis for introducing, leading and evaluating the change.

The decisions to commence the service from a community base and also to include women with risk factors proved to be important in the long term. To this day, the specifics of having a community base for the model and its overtly collaborative relationships that enable women with risk factors to access it are highlighted as two of its more positive attributes. This is reflected in the title of the published paper is "Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care" (Homer, Davis, Brodie, et al, 2001).

Transferring antenatal clinics to the community was a radical step for Australian maternity care at that time. Setting up the community based clinics with midwives, medical staff and allied health services (such as pathology and ultra-sound), involved extensive consultation. I worked with the midwifery leaders within the unit and the community health staff to obtain premises, equipment and practices that were acceptable and sustainable. One of the venues for the clinic was a non-government agency – the Family Planning Association Clinic. As a group we supported and encouraged each other and drew on the positive feedback from the consumers to keep us buoyant. Ensuring an appropriate and effective role for medical staff in the community clinic was a critical process. In the initial phase I conducted clinics with the midwives with the staff specialist obstetrician on site ready to be consulted as necessary.

The Professor and Director of Obstetrics provided a 'shield' from negative influences including threats or obstruction to the organisational changes. These influences were perceived to be mainly coming from obstetric VMOs who had no influence, authority or control over the impending changes.

Over a period of months, as trust built and clear referral processes were in place, I gradually withdrew from the clinic to enable the midwives to assume greater autonomy and responsibility for their practice. The staff specialist continued to provide a consultancy role on a 'needs only' basis, as requested by the midwives or the women themselves. An obstetric registrar, rather than a staff specialist supported one of the clinics. This reflected a degree of professional recognition, trust and respect we had developed with the staff specialist who in turn encouraged

the registrars to embrace the new model of care and to trust and work in collaboration with the midwives in the community based clinic. His leadership in this regard was noteworthy.

This collaborative professional relationship in maternity care, based on a clear understanding of roles and a growing level of mutual respect between midwives and obstetricians, is reputed as a model to other organisations. In drawing on the findings of my earlier Masters thesis (Brodie, 1996a) I formed the opinion that mutual trust and respect was central to the survival of our model and central to best practice in maternity care.

The reason that we were able to build trust and mutual respect appeared due to a number of contextual factors. Sound leadership across professional disciplines and effective pre-planning and management of organisational change had created the following organisational context for practice:

- Shared understanding and enthusiasm for the model of care and the vision for the maternity unit
- Shared professional support between members of the team
- A majority of motivated employees from midwifery and obstetrics with good communication skills
- A level of excitement and anticipation of doing something good for the community, health care and the professions
- Being at the 'cutting edge' of service innovation
- Feeling respected, with learning and experimentation being encouraged and supported
- Recognition that midwifery autonomy and collaboration were inter-linked

These were the obvious features of the organisation and its management. Other features were less overt but equally important and played a significant part in the success of the project. At a personal level the mutual support and shared philosophical beliefs of the individuals involved most closely in the new models of care and the organisational cultural change, were also what enabled it to succeed. For the most part, these people genuinely liked each other and wanted to work together. The unit managers and other leaders supported and enhanced facilitation of the new model and the necessary changes across the organisation. For some, it was not necessarily what they would have chosen but they accepted that this was

progress for the benefit of consumers and for the most part they agreed to either facilitate, or not obstruct, the institutional reform process.

The head of the division of obstetrics and the staff specialist obstetrician both continued to provide overt support and 'protection' whilst the model was becoming established. This included addressing concerns and challenges through open discussion and reassurance of VMO obstetricians or GPs, continually espousing the efficacy and benefits of the innovation. This 'protected' the research process and minimised the chances of sabotage of the new model.

On reflection, the key leadership strategies that were adopted as part of an overall change process for maternity care at this hospital could be described as:

- Use the legitimate authority of research to introduce new models of care based on successful models elsewhere in Australia
- Improve and evaluate midwifery practice and maternity care outcomes through the adoption of evidence based approaches
- Foster inter-disciplinary collaboration and development of relationships of mutual respect and ultimately, trust
- Support and enhance clinical leadership, professional development and greater visibility of midwives
- Share responsibility for driving changes
- Continually reflect, review and adapt practice and services in keeping with consumer feedback and research findings
- Strong and consistent support and recognition from the heads of the departments involved in both midwifery and obstetrics
- Integration of research and clinical practice throughout all activities
- Continuous communication and feedback through formal and informal structures
- Promote, evaluate and disseminate the successful innovations and achievements to other institutions and care providers as well as to the local community

During the two-year period of implementation and evaluation of the team midwifery model I gained further experience as a leader. I was encouraged and supported by the divisional midwifery manager and my colleagues as well as the midwifery

academic leader. Within this context of professional support and recognition, I was able to complete my academic studies – the Master's [of Nursing] thesis.

Conference papers and publications that reported the process and achievements associated with the new models of care and changed practices enabled dissemination of the benefits of the work to others. These are listed in Appendix H. In the capacity of midwife consultant, I represented the profession and the unit on a number of regional and state committees concerned with maternity service development, policy, practice and standards of care. This affirmed the work of the individuals involved and also raised the profile and status of this progressive maternity service locally, nationally and later internationally. These are explored more fully in the third case study.

Conclusion to Case Study One

Through several varied clinical practice leadership roles across a period of more than fifteen years I observed first hand the nature of 'effective' and 'ineffective' leadership, the particular attributes of effective leaders and the environments in which leadership can occur or is hindered.

I identified a number of key factors that emerged from these experiences to describe 'what works' and 'what is problematic' when introducing and developing new models of maternity care that give greater recognition to midwifery. The particular traits and attributes of each of the leaders have been described and interpreted. Just how much these, or indeed the structures, organisational contexts and collaborative relationships that we developed could be transferred to other settings, is uncertain.

How some of these experiences and insights were applied and tested elsewhere, including the processes used and degree to which change could be successfully introduced in other organisations, is the subject of the next case study.

3.3.8 Case Study Two – Leadership in Organisations

Introduction

As described in the introduction of the portfolio, in early 1999 I was employed full time as a research midwife in the AMAP study. This opportunity came at the end of a two-year period spent in setting up and integrating the new model of maternity service provision that, provided continuity of care by midwives in a community setting.

During the period of employment with the AMAP study, I continued to receive requests from health departments and regional health services to provide expert opinion and technical advice regarding the introduction of new models of midwifery care. Given the scope of the AMAP project, namely to explore the 'barriers' to midwifery, it was seen appropriate for me to continue to provide some advice. The consultancies were limited in number. I agreed to do them on the condition that I would be able to use them as research opportunities as part of the AMAP work and this portfolio, which would potentially allow me to gain insight into some systemic barriers to midwifery models of care. It is within this context that the second case study was developed.

I was engaged in a number of clinical service reviews of regional maternity systems and practices in the form of invited consultancies. I have chosen to explore three of these in depth in this case study. The consultancies were conducted in different and contrasting organisations. One involved assistance in the develop of a strategic plan for maternity services in a semi-rural area health service; the second was a review of clinical services and outcomes in a regional maternity unit; and, the third was a review of a clinical service within a tertiary level urban hospital.

For each of the three consultancies, the technical advice was provided on the explicit condition that I could draw upon the experiences gained in my roles as both a technical consultant and a researcher for the purposes of my doctoral studies. These organisations were in the process of refocusing and reviewing priorities in the planning and provision of maternity services with an emphasis on incorporating evidence based-care and a greater role for midwives. The terms of reference for each consultancy were confirmed through written correspondence that explicitly acknowledged my student status and my wish to learn from, and possibly use, the experience in my studies. In my role as consultant I was able to contribute skills, knowledge and midwifery leadership through an iterative process of inter-disciplinary collaboration and consultation.

I was contracted to do the reviews on the basis of my work in developing and implementing midwifery models of care and evidence based practice. As such, I approached each of them from this philosophical perspective, with an emphasis on the need to recognise, and in some cases expand, midwifery's contribution to maternity services. The rationale for this approach was sound, provided I cited the evidence and applied it to the Australian health care setting.

Aim

The aim of Case Study Two is to describe and analyse leadership through my role as outsider to a number of different organisations seeking to introduce new models of care into their maternity services.

Method

Data for the study were collected through the period of time each consultancy took place throughout the years 1999 to 2001. The approach used for each consultancy was similar. I prepared extensively prior to commencing the consultancies through extensive reading of background and supporting documents from each of the services. A review of relevant literature, methodology, data and policy sources was also conducted.

Data in the form of the demographics for each service including population base, throughput of clients, workforce numbers, clinical outcomes, planning documents and reports, quality initiatives and benchmarking exercises were all gathered and analysed.

Each organisation differed in terms of size and scope of service provision, geographic location and contrasting requirements and priorities for the review. This enabled me to examine some of the contrasting 'contextual' complexities of leadership for change in health care across different settings. These contrasts assisted in triangulation (Jick, 1983) of data sources, not to confirm each other, but rather to contribute their own original perspective and experience. The range of complexities and contextual variation across the three separate organisations chosen included: a threat of closure, acute shortages of midwives, concerns with clinical standards of care and threat of withdrawal of medical services. Each of the three terms of reference is presented in Appendix C. These exemplify differences in size, scope, context and desired outcomes of the three reviews, which further add to triangulation of data sources (Sandelowski, 1993).

An additional variant related to one particular consultancy where I was part of team that included a consumer, an obstetrician and a general practitioner in the review process. This offered a further dimension to the experience of leadership namely the incorporation of inter-disciplinary collaboration that included consumers' contribution to review, planning and future maternity services provision.

The consultancies also shared a number of features. These were that in each case the director of nursing / midwifery initiated the process and as such was its leader at

a local level. During initial contact, we explored with them, issues of concern and some of the contextual background including political and organisational factors that led to the decision for the review as well as factors that could potentially impede or facilitate the process or outcomes.

Results

A The outpatient's department of an urban tertiary hospital

The purpose of the review was to assess the current activity and resource utilisation and to provide direction and guidance about future service needs and developments. Specifically the introduction of models of care involving greater access to midwives was anticipated and therefore, an evaluation of existing roles, practices, views and attitudes of midwifery staff employed in the department was required. This was intended to assist in identifying any organisational factors that may be barriers the proposed innovations.

Context

The midwifery leader of this organisation initiated the review with the full support of the medical and administrative directors. The catalyst for the review was a shared commitment to make changes to the organisation and 'flow through' of women clients and to increase access to a range of midwifery models of care in this facility. With a history of traditional medical hierarchical decision-making, the managers of this hospital sought to change the organisational culture. As part of a wider change process, significant resource allocation had occurred previously to enable change management workshops and attendance by many at 'transformational leadership' development courses. The leaders were now seeking changes to the overall structures, systems and processes of care. I was required to review staff numbers and resource utilisation, activity and workload and make recommendations for improving continuity of care and efficiency. Recommendations were to reflect current 'best practice' and greater consumer focus and incorporate contemporary evidence, including access to midwifery models of care for larger numbers of low risk women.

Method

A range of different methodological approaches was used to gather data. These included:

- A review of available statistics and current staffing levels.

- Revision of a sample of Policy and Procedure/Protocol manuals used as guidelines for clinical care in the department being reviewed.
- Direct observation of care and practice in a sample of the various different services.
- Individual interviews with staff and key stakeholders of the as well as managers and leaders from associated departments.
- The conduct of a focus group with administrative staff to identify and explore issues relevant to them.
- Analysis and interpretation of written information, policies, standards manuals and other internal documents and reports.
- Recording of personal reflections and observations of leadership and organisational contextual factors

I reviewed all relevant documentation followed by a series of interviews and spent time as a 'participant observer' (Hunter, Lusardi, Zucker, Jacelon, Chandler, 2002) in the clinical area. As a clinician, I believed that most of the information I required would be accessible through watching and listening to individuals while they practised.

Observations of practice and individual roles occurred over a total period of twelve days, spread across a two-month period. This allowed for variations in workload and activity and changes of personnel to be observed. This time frame also had the benefit for both the staff and myself to reflect on the review process and emerging information and to return with additional questions or responses. Over the period of two months I was able to develop rapport with some individuals who, once they felt that I understood their circumstances, offered insights that were valuable in enhancing the review process and outcome.

Data Collection

The twelve-day period of observation and preparation of this report spanned the months of December 1999 to January 2000. Data were provided upon request including the demographic information for the service including workforce numbers, clinical outcomes, reports and summaries of quality programs.

At the outset I identified key personnel and made appointments to interview them, however during the course of the review, others came forward and requested to also be interviewed. All midwifery and clerical staff and 75% of medical staff attached to

the service were interviewed. A total of thirty (30) individual interviews and two (2) focus groups were conducted. Direct observation of a range of services being provided by midwifery, obstetric and gynaecology staff also occurred. This included the public waiting area. Informal discussions with women and their partners also took place.

Observational contextual field notes were made of the processes used to engage stakeholders and others in the review and the expected outcomes. At times I needed to first provide some information [for example a journal article about the merits of continuity of midwifery care] and return at a later date to discuss with the staff member their views and responses to the idea that such a service might be introduced in to their facility. Other data consisted of notes made during interviews held with leaders and others about the potential for change and the introduction of new systems and models of care. Through this process I was mapping resistance and / or cooperation and developing an understanding of the context for leadership and the introduction of midwifery models of care.

Results

The collection of field notes that recorded my observations and insights regarding leadership and the introduction of midwifery services into this organisation were reviewed and analysed these using thematic content analysis (Strauss A, 1987).

Analysis of notes made during the review reflected a level of fear of change amongst the staff along with a perception that they had 'seen it all before'. On the one hand, individuals were sceptical that anything would change, whilst on the other there was concern that change might actually affect them and their roles. There had been a new midwifery unit manager recently employed and she was expected to introduce changes to the service. This expectation was based on a view that inefficiencies existed and that these were associated with significant structural and process problems. Despite a clear vision of what was needed, this midwifery manager was held back by firm medical control and some VMOs' reluctance to adapt services to increase access to midwifery models of care. My observation was that whilst she did hold a formal position of authority, she did not have a recognised leadership base or access to knowledge, resources including the evidence on which to formulate an argument for the proposed changes. She had worked previously as a manager but was not a strong leader. She had a vision and a position of authority but was not able to exercise and implement this although her staff expected her to lead and for them to follow. I saw that what was needed was knowledge,

information, access to the evidence, advice about 'structure' and 'process' improvements, and leadership support to achieve and sustain the desired changes.

The characteristics of other leaders in this organisation were observed. Directors of the service - midwifery, medical and administrative were well informed, motivated and skilled. They had developed a vision for where they wanted the service to go and they were committed, having also resourced leadership development projects for staff. They shared a philosophical vision but required outside expertise to inform and advise about specific details (the 'how to') for service changes and the implementation of new models. They were enthusiastic and supportive of their staff, encouraging professional growth and development and were willing to be creative in finding additional resources to see the vision through. This was reflected in their decision to engage me as an outside consultant to provide the expertise that they did not have access to locally.

Contemporary evidence, relevant to this service, was included in the report and made available throughout the consultancy period. In addition I was asked to provide an educational session on the general principles of midwifery models of care, which was well attended. Recommendations were made for 'structural' improvements including re-configuration of the physical environment and review of the number of women seen at each clinic session. Improvements to 'processes' of care were suggested that could increase continuity of care, choice and access to midwifery services. Potential efficiency gains were demonstrated as well as the possibility for improved forms of care that were more satisfying for women and gave more visibility to midwifery.

I perceived that the major opposition to these recommendations being implemented would come from the senior medical staff who had become very used to one way of providing care. Each one had his/her own particular way of providing the service and each was slightly different. A common feature here was the medical hierarchical approach that I had seen elsewhere and which was no longer appropriate in contemporary evidence based systems of care. In my view there was an enormous waste of midwives' skills with much of their time spent in a subservient role either assisting doctors in routine care or waiting for them to complete routine care. Most midwives in this service did not have experience of autonomy or responsibility for providing primary midwifery care. During periods of observation, often whilst midwives waited for doctors who were running late, I was able to explore with them their desire and confidence to provide care on their own responsibility, especially for

well women who did not require medical attention. Thus, the context for leadership to succeed and the organisation's readiness for change were further assessed and analysed.

The report and its recommendations were presented to the Board of the hospital and within two months received full endorsement. Structural changes to services, including greater access to midwifery models of care for women were implemented over a six-month period with only minor challenges and opposition. These changes were progressively implemented as senior medical staff retired or chose not to renew their contracts.

The success of the implementation is attributed by the leaders of the service as being due to the strong evidence provided in the report and because so many of the staff felt that they were involved and engaged with the process. In particular the midwifery unit manager had a well-informed base, a framework and a clear rationale on which to implement her vision for the service. Improved efficiency in utilisation of resources was achieved. Midwives adapted in different ways to the changes. One or two moved to other areas of the hospital but most embraced the new roles including greater autonomy, and subsequently reported increased job satisfaction. Anecdotal reports highlight greater consumer satisfaction related to less waiting time and more time with midwives. Through the introduction of a number of new 'midwifery led' services the role and function of midwives was made more recognised and visible.

B. Maternity services across a rural health service

Context

The nursing director of a large rural health service approached me with a view to being a part of a team to review the region's maternity services. She had very keen to have a midwife included in the review, which was being planned by others members of the Executive team. She was concerned that the review might proceed without a midwife involved. Again the structure of the review process was important from the outset.

This region covers an area of about 24,000 square kilometres and provides health services to approximately 250,000 people. The annual birth rate is approximately 3,500 spread between eight separate maternity units. These maternity units were showing significant variance in clinical practices, outcomes and forms of care available. Some provided women with a flexible range of choices and options for care, whilst others were quite restricted. This did not appear to be substantiated on

the grounds of available expertise or resources but rather more on local customs and tradition. The director was new to her role and was keen to see how this region compared with other similar services' benchmarks. She sought advice on strategies for improved services that were in line with evidence and state and national policy directions. There had also been ongoing requests from local midwives and consumers in the region for greater access to midwifery models of care.

I was asked to work with a consumer, an obstetrician and a GP as the maternity services review team. I ascertained very early in the discussion that this review was implemented from 'outside of' or 'from above' the clinical maternity services. As such I instantly perceived barriers to its process, implementation and outcomes. I requested early on that the review must have a clear and overt focus on collaboration and the need to engage clinicians at every level of the process. I recommended that the 'spirit' of the inquiry centre on improving services for the community as well as fostering relationships and inter-disciplinary collaboration between health professionals, across the various separate units. We were asked to review all aspects of service provision including variations in practice, policy and outcomes, the range and types of information and education offered to women, as well as the appropriateness of the current models of care. I was informed of whom the other members of the team were and whilst I had not previously met any of them I was confident that we could work together successfully.

Method

I liaised with the project officer and team members via phone and email initially and through this process we agreed how we would structure the review and on the terms of reference. These were to examine variance in clinical practices, outcomes and forms of care available and to make recommendations that would enable more flexible choices and options for care including access to midwifery models of care (Appendix C). Background data and documentation was forwarded as pre-reading prior to three days of site visits and interviews.

The review team convened for three days and visited all eight hospitals. A description of the models of care available at each site was reviewed as well as results of consumer satisfaction surveys, which had been administered as part of the preparation for the review. The team had a particular emphasis on reviewing current service provision and maternal and neonatal outcome data for Aboriginal and Torres Strait Islander women because of the poor birth outcomes experienced by this group of women. Information on critical incidents involving

women or newborns was also reviewed. Unlike the other consultancies I had been involved in, this project had a much stronger emphasis on review of quantitative data and written information, so much so that members of the team agreed that it was not possible to review for all that was produced for consideration. Pragmatic decisions were made on what information was essential to the review in order to allow adequate time for talking to individuals and groups representing key stakeholders.

Given the agreed principle that the review process would also have a focus on 'fostering relationships and inter-disciplinary collaboration between health professionals' we requested additional time for discussions with clinical staff. The review team sought to engage clinicians in developing a range of recommendations for models of care that centred on the need to respond to national and state health policy directions and evidence of 'best practice' from published literature and from other facilities.

Data Collection

Current service provision in relation to evidence-based practice and state Health Department policy reports and publications were examined. In total we interviewed, or conducted focus groups, with 32 health professionals. Documentation, including profiles of services in each hospital, five submissions from stakeholders, policies, protocols, consumer satisfaction surveys, internal reports, proposals, information on critical events, intervention rates and clinical outcomes were all reviewed by the team.

I recorded field notes about the process of engaging others in thinking about changes to their services including the introduction of midwifery models of care. I observed and listened to the various stakeholders and recorded my observations in particular with regard to the leadership in evidence or that was perceived as being needed.

Results

Throughout the review I observed individuals within their roles as they engaged in discussions about the introduction of new policies, practices and models of care. I noted reluctance by many GPs to embrace midwifery models. These were perceived as impacting on their professional practice domain and [presumably] their income. In the absence of a clear funding stream to employ midwives, and despite the evidence available, many felt that it was not feasible or necessary in this region. In

contrast, consumers and midwives were most vocal and enthusiastic about the potential for midwifery models of care.

In my analysis and interpretation, the review process lacked a clear point of clinical leadership at a local level. This is evidenced by the way the review was set up with no single representative from the Health Service being designated as the 'leader' of the maternity services or as the person to take the recommendations forward. We were instructed to prepare the report for the Area Health Board. The consequences of this were that most of the negotiations and discussions were held with the clinical review team and the project officer allocated to work with us, who did not have either an obstetric or midwifery background. Whilst there were individual interviews and discussions with clinicians, there was not any direct link to clinical leaders and decision makers who would have the ultimate and ongoing responsibility for implementing any proposed changes.

My assessment of this approach was that the four external consultants were seen as the 'experts' who were asked to come into the service to provide advice and make interpretations and recommendations. This was evidenced by the frequent comments to this effect received by participants in the interviews. Despite our efforts to engage local clinicians in the process we were only given the information that we requested. Very few participants appeared interested or willing to engage with us in the process of exploring potential changes to the service. In retrospect, the review process should have included a number of local clinicians; [for example a GP, a midwife and a specialist obstetrician] who could convey the spirit and intent of the inquiry back to their colleagues. A strategy such as this, introduced at the outset of the review, may have also enhanced the subsequent implementation process and final outcomes. On reflection, this is no doubt an important principle in the structuring of consultancies such as this. Engagement with stakeholders at a local level seems critical to the subsequent adoption of any recommendations.

There was no time allocated for building relationships between the review team and the clinical staff. Observation of actual clinical practice was not included in the terms of reference. The bulk of the report and its recommendations were underpinned by interpretations of the quantitative data, which were used as triggers for questions during interviews with clinicians and managers. Whilst responses were forthcoming, the lack of an appropriate structure and process to enable a degree of rapport building and trust to allow deeper exploration of issues, were limiting factors in the review.

My observational notes about the leadership and barriers to implementing new models of care, reflected concerns of several people who perceived the review as 'outside of their influence' and as being 'imposed from above by senior management'. Many individuals had prepared large quantities of data and reports for the review and were then afforded only a brief time with the review team. Others, particularly some of the doctors, had not responded to a request for written data and spent their interview time being critical of the health service administration and the state government. On the question of policy review and development, this appeared to be an ad hoc process with little liaison between the various units, each one having their own policies and some having separate policies for each medical officer. Duplication and overlap of services and policy were common with little evidence of collaboration or continuity between the professional groups. Clinicians were focused on their separate roles and functions and a culture of individualism was evident.

This review was an overt attempt to demonstrate leadership and to move the services forward, in keeping with evidence based care, benchmarking and state policy changes. There was very little leadership or collaboration within and between obstetrics, midwifery and the broader management of the health services. The nursing director had a vision for maternity care and sought to bring this region into line with similar facilities elsewhere. The Area Health Board and the administrative leaders supported this initiative. However, significantly, there was little evidence of medical support for the review, as the region did not have a point of leadership for obstetrics with each facility having its own head of department. Structures that enabled leadership to occur were missing.

The review was seen by many doctors as a waste of time at worst, or not relevant to them and their roles, at best. For example many of the GPs stated that they "would not have much to say" and that they "didn't see the point" as "things aren't going to change". Many offered suggestions that would expand their intake of clients and clinical interests but very few were able to suggest improvements to the overall systems of maternity care, policy, standards and protocol development or to the range of care options made available to women. In contrast, consumers and midwives both demonstrated that they were very knowledgeable and had investigated the outcomes and experiences of models of care in other parts of Australia. They were ready to make recommendations and substantiate these with supporting evidence. As such their input to the review had a significant influence on the outcomes and recommendations.

Another aspect of leadership that emerged was that several midwives, who were not in management roles with authority or power, were able to articulate what was necessary for leadership in maternity services. They reported feeling frustrated with the lack of leadership, experienced over a long period of time and which they perceived would not come forward from the existing organisational structures and roles. The review team were convinced by the substantial case that these midwives made for recommending a new role as a point of leadership in maternity services across the region: an Area midwifery consultant. This role would assist in leading the implementation of recommendations contained in the report. These included constitution of an Area wide maternity committee, formation of a maternity service plan and the development of standardised protocols and systems of care across the area health service that could improve networking and maternity services overall.

Over the three days that the review team had worked together intensively, a degree of trust and respect had developed. Inter-professional rivalry was absent as we embarked on the task of reviewing the services and also modelling the relationships we had discussed and hoped to encourage in others. As an example of the depth of respect and collaboration that developed within the team, we were able to move our position and recommendations regarding homebirth and waterbirth. Initially the two medical members of the review team had stated their opposition to two clinical service issues - waterbirth and homebirth, reiterating the views of their professional colleges as a means of substantiating their positions. They did not wish for either to be supported in any way, in the final report. The consumer and myself respectfully continued to state our position, which was to support the development of a policy that incorporated the best available evidence and recognised a woman's choice in these issues. Over the course of the three days, and in ensuing phone contacts, they were able to move to a position of accepting these options as a part of offering women a choice. Providing certain parameters of safety were developed, they were able to support the development of policies for waterbirth and homebirth. Through the provision of evidence and leadership within a context of trust and respect, we were able to collaborate to potentially improve policy and systems of care.

The final report was submitted to the Board after two months and was subsequently endorsed. Follow up contact some 18 months later has revealed that very few of the recommendations have been implemented. Anecdotal reasons given for this range from inadequate funds to implement new positions and services, to a lack of widespread acceptance of the report and resistance by some to the introduction of midwifery models.

My analysis of this situation is that there was an initial lack of collaboration and engagement of key stakeholders in the process of the review and as such very few of them felt involved, willing or able to influence its direction and process. There was no ownership of the process or its outcomes. This perceived ineffectiveness, I believe, is linked to a lack of leadership in maternity services, which was exemplified by some participant's statements that 'nobody is driving the bus'. The review team were engaged as outsiders and remained 'outside' the organisation for the most part. We produced a review that reflected contemporary 'best practice' in maternity care and recommendations that the management felt they could implement. What were missing however were the necessary structures and 'process' of leadership and engagement of key stakeholders that would allow them to feel a part of the planned changes and assist in their successful implementation. Without this, the review and its recommendations, like the review team itself, remained 'outside' of the health service and this particular organisational culture.

C. A small rural maternity service

Context

I was invited to conduct a review of midwifery and neonatal services provided in two facilities in a rural setting, which provided care for approximately 1200 -1300 births annually. The scope of the consultancy included reviewing midwifery practices and models of care, identifying gaps in service provision and providing a framework for improved co-ordination, continuity of care and enhanced midwifery development. This was within a context of threat of a closure to one hospital ('the smaller unit') and subsequent expanded capacity and delineation of the other which catered for about two thirds of the births ('the larger unit'). These changes were being proposed as a solution to lack of availability of 24-hour obstetric and anaesthetic coverage. The review was expected to recommend how maternity services could be integrated and networked across the community and linked to the larger hospital, including the skill enhancement of midwives. In this setting the potential for midwifery models of care had previously been explored and discussed and reportedly some interest had been shown. Midwives in the smaller unit reported a degree of autonomy in their practice that was not evident for midwives in the larger unit. The gradual cessation of obstetric and anaesthetic medical coverage appeared to herald an inevitable closure of birthing services at the smaller unit, which was located twenty-five minutes away from the larger service.

Method

The health service initially sought to have a combined medical and midwifery review of the maternity and perinatal services. Due to the difficulties of not being able to have all members present at the same time, separate 'medical' and 'midwifery' reviews were conducted. I therefore consulted with the doctors who had completed the medical review and considered their findings and recommendations as I proceeded with the midwifery services review.

Data Collection

Throughout the three-day review period I observed the roles and functions of service managers and directors, within the context of day-to-day practices and recorded field notes of what I saw with regard to leadership styles and reports of leadership activities and functions. I was shown the facilities of both hospitals and the plans for the development of a new maternity unit in the larger facility that would have the capacity to incorporate additional demands if the two services were amalgamated. I engaged in discussion and exploration with the midwives regarding the implementation of new models of care that would enhance continuity of care and expand the contribution of midwives to mainstream service provision.

Interviews and focus group discussions were held with the regional executive staff [5], midwives from the two hospitals [16] and the community health services [4] as well as GPs, obstetricians and paediatricians [6 medical staff in total] associated with both hospitals. I reviewed local, regional and state health department policy reports, protocols and procedure manuals, service utilisation information and clinical indicator data from both hospital sites.

Results

All midwives and more than half of the GPs informed me that significant numbers of women in the local population wanted a 'low-interference' style of care and had become used to that approach at the smaller unit. In contrast, the larger unit was reportedly perceived by local women as more 'high tech' and 'medicalised' and in need of a 'low intervention' option of care if it was to cater for consumers from the outlying regions. Within this context I suggested that a possible alternative to closing the smaller unit could be to explore the introduction of a 'birth centre' run by GP's and midwives only. This was theoretically possible because of the availability of adequate numbers of skilled midwives and GPs. I provided examples of similar services in rural settings in other countries that had been shown through research to

be safe and beneficial. This was seen as a radical view and not politically popular with the medical profession or health risk insurance companies in Australia at the time. Also, in this region, such an idea was not supported by the current group of GPs and had already been rejected by the medical review process that preceded this review.

The medical opinion regarding the best way forward for these two units was to consolidate services to one site, with the facility to gradually become a major obstetric centre. It was suggested that a birth centre adjacent to the main birthing unit with full back-up facilities would address the needs of women seeking 'low intervention' type care. Further, the smaller unit could continue to provide antenatal and postnatal care locally.

Whilst the decision was not popular with the majority of midwives in the smaller unit, it was seen as a 'fait accompli'. I therefore pursued other opportunities with them regarding how they could continue to utilise and maintain their skills and how midwifery continuity of care could be incorporated into the maternity services overall. I suggested that midwifery visibility was high in their small town and if there was no attempt to maintain a profile for the midwives then the profession could lose its recognition and viability locally.

At the same time I was provided with a copy of a plan to introduce a midwifery model at the larger unit, which had been prepared by the midwives there. The proposal had been developed some four years earlier and had been through repeated processes of review, discussion and adaptation by several stakeholders. There was perceived resistance to introducing this model, related to concerns of managers about costs and the additional resources needed. There was also reported a general lack of leadership and explicit support for 'midwifery led' services. Despite evidence of cost effectiveness and improved outcomes, the leaders of the organisation had reportedly continually held the model back from implementation.

Upon closer review, I saw that the midwives had developed the proposal themselves, drawing on research evidence and reports of similar models elsewhere. The document described an innovative model of care similar to others that were emerging in many units around Australia at the time. However, there was a lack of any evidence of collaboration with other key people such as consumers, the managers of the service, obstetricians, GPs and community based child health nurses.

I suggested that fundamental to the future success of the model would be the incorporation of collaboration between midwives, doctors and community health care staff. Strong links to the community were suggested as critical if the model was to realise its potential to achieve health gain and improve outcomes, such as is anticipated with a primary health care approach. Clear guidelines, mutually agreed between midwives, obstetricians and GPs were also recommended as part of ensuring successful implementation. Part of the process of engaging with the midwives led to changes to the document being amended to take account of some of these issues before it was resubmitted. In addition, a steering committee with representation of all stakeholders including consumers was recommended to assist in, and enhance, the implementation process and the long-term sustainability of the model. These structural changes were recommended to improve the process of developing a midwifery model that would be acceptable to all.

Within this review process, leadership across the services was not evident, nor was there any evidence of collaboration at a 'systems' or organisational level. For example, some staff reported that whilst perinatal mortality and morbidity meetings were held at the larger unit, midwives were often left off the invitation or advised with insufficient notice. These meetings were reported as mainly focusing on reports of statistics with little critical analysis, debate or case discussion.

Within the smaller unit, it appeared that morale amongst the midwives was high and the unit had been functioning effectively for many years. For example, whilst there was a unit manager, her role primarily focused on resource allocation and management tasks rather than development or expansion of the midwifery role or practices. The midwives showed enthusiasm about their role, with reports of 'Meet the Midwives' stalls at the local shopping centre, and wearing of midwife logos on T-shirts at work. Midwives and doctors reported that they 'understood and looked after each other' and there was evidence of respect, trust and in some cases, individual friendship between the professional groups. In contrast in the larger unit there were distinct groups or 'camps' of professionals with consultation occurring on a needs basis only, centred on what was required for clinical care. The development of midwifery practice and expansion of the role of the midwife as recommended in policy and supported by evidence was seen only as a remote possibility and professional aspiration for midwives in this unit. Without leadership and support many felt that it could not be achieved.

Midwifery leadership was identified as critical to the development of future maternity services and midwifery practice in particular. Recommendations within the report linked the anticipated appointment of an 'midwifery consultant' as integral to enhancing visibility and recognition of the professional roles and functions of midwives across the region. In the report, the introduction of midwifery models of care, increasing utilisation of midwives' skills and using evidence in the collaborative development of maternity services were recommended and supported by midwives and service managers as key strategies for the future. Making midwifery visible and accessible and increasing the opportunities for collaboration to occur were recommended as important components of future management structures and service provision. Such initiatives would also address other goals of the review, which were to recommend how maternity services could be integrated and linked across the community, and the necessary skill enhancement of midwives that would be required to achieve this.

The review provided a range of recommendations and strategies to enable effective linkage and networking of the maternity services across the region. Nonetheless, the decision to move all services to one major hospital where birthing services would be centralised was made prior to the report being completed. Midwives and GPs at the smaller unit were offered certain options that involved them in continuing to provide the bulk of antenatal and postnatal care to local women. They were informed that all births would take place on one site: the larger unit. The introduction of models of continuity of care utilising the skills of the local midwives and GPs were included as additional components of the decision. Many of the local midwives and GPs were reluctant to embrace the changes and did not see how such a model could function effectively or be acceptable to the community. Essential structures and processes for leadership and collaboration amongst stakeholders including community members did not appear evident. For the most part, there was an acceptance, preceded by only a small protest that the changes were unavoidable, that the local services would be centralised into the larger centre.

As such, in the final report I recommended that decisions about number and type of maternity facilities should be made in consideration of and commitment to, an agreed plan to develop a range of models of care. This should include locally accessible antenatal and postnatal services close to where women live developed as 'outreach' clinics. Increased utilisation of midwives' skills in provision of these services was recommended as well as the development of evidence-based, collaboratively developed policies and practices.

The report concluded with a strong recommendation that all clinicians involved in maternity care must be made aware of the contents of the report. This was intended to assist in establishing greater understanding of the broader issues and context that had initially stimulated the review. It was also suggested as a way of assisting the acceptance and adoption of the ensuing changes across both maternity services, including greater recognition of the role of the midwife.

Anecdotally, six months later it was reported to me that many clinicians never saw the final report and that changes to the services proceeded quickly such that the majority of women were required to travel to the larger facility for their care. The smaller unit now has only a small number of women accessing it for postnatal inpatient care.

Conclusion to Case Study Two

Case Study Two has described and analysed leadership as observed and experienced through my role as a consultant, providing advice to organisations seeking to introduce new models of care into their maternity services. In this role I was able to observe first hand the leadership of others. I was also in a position to contribute skills, knowledge and midwifery leadership of my own, through processes that both promoted and modelled inter-disciplinary collaboration and consultation. The case studies have analysed leadership across different types of maternity services and organisations. These ranged from a small rural unit, to a large service in a tertiary referral hospital.

The studies provide data and analysis that help to explain why change is so difficult to achieve in the reorganising of maternity services and in making midwifery more visible. They also demonstrate how effective leadership and collaboration can address some of the barriers experienced in the development of evidence based maternity services and new models of care, across different levels of the health system.

It was evident during the reviews that there was a significant lack of understanding of the role of the midwife. In particular the policies, philosophy of care and organisational culture within the different organisations showed little recognition of the midwife's role as a 'safe' primary care giver (Commonwealth Department of Health, 1993). I surmised that a more formal and widespread leadership effort to influence public health policy that recognises the need for greater visibility and recognition of midwifery was required.

Examination of the range of policies and documents that influence the planning and provision of maternity services more broadly, revealed further the lack of visibility of midwifery. It was evident that leadership that used evidence and primary health care approaches could provide the platform for a range of initiatives to enable greater recognition of the benefits of midwifery within the development of health services policy.

In the following case study I describe and analyse active participation and experience of leadership and collaboration to address this issue. I explore and analyse practical experiences of leadership that were designed to increase the recognition of midwifery in health services policy development, and in improve the effectiveness of maternity services across the state.

3.3.9 Case Study Three – Policy Leadership in Maternity Services

Introduction

The third case study looks at the broader leadership setting of state-wide maternity service policy and planning within a context of government responsibility for maternity services strategic development, restructuring and resource distribution. Here I describe and analyse practical experiences of leadership that were designed to increase the recognition and visibility of midwifery within maternity services policy development. This took place, as policies designed to improve maternity care were being developed and implemented. I was particularly focussed on explaining how midwifery contributed and was incorporated into these processes.

In mid 1998 I was invited to take up a short-term secondment position as a Project Officer to the state health department in order to provide leadership and advice on midwifery and maternity services planning. During this time I worked with an interdisciplinary advisory committee across a period of twelve months to develop and write a strategic plan for maternity services for a state in Australia (NSW Health Department, 2000b).

After completing the eight-month secondment I continued to play an ongoing role in the provision of advice and information to the state health department, on a range of midwifery and maternity service issues. This included consultation and policy advice regarding homebirth policy, accreditation of independent midwives, midwifery workforce planning, standards of midwifery education, regulation and practice and the introduction of midwifery models of care. My role, after leaving the secondment was in a dual capacity. I held a substantive employee role as midwifery consultant

developing midwifery models of care in one of the teaching hospitals, and I was the president of the NSW Midwives Association Incorporated, the state branch of the national professional midwifery organisation known as the Australian College of Midwives.

Aim

This case study describes and analyses active participation and experience of leadership and collaboration to address the lack of visibility of midwifery at a strategic policy development level within state wide maternity services.

Method

Sources of data for the study involved a range of current local and national reports and publications relating to maternity services development as well as state health department planning documents used for health service planning more generally. The latter reflected the overall broad strategic direction for this state's health planning and quality initiatives. Mindful of the health department's philosophical underpinnings of 'primary health care' and equity and access for all, I intended to make sure that a similar direction would become the basis for the maternity services planning process.

A review of the relevant evidence and international literature regarding the efficacy of midwifery models, including national policy documents, state wide strategic direction reports and published data on the outcomes for midwifery models, provided the contemporary contextual basis to the study. In particular, documents from the United Kingdom where similar strategic developments [involving greater recognition of midwifery] were occurring, enabled me to prepare well and to be as up to date as possible on relevant initiatives, prior to starting in the role as adviser.

As in the previous two case studies I recorded field notes and collected press releases and announcements from the media that would reflect the direction the government was taking, with regard to the leadership of maternity services generally, and the recognition of midwifery models of care more specifically. The construction of this case study initially involved gathering all of the related data together into a narrative (Patton, 1992). Through the process, I sought to understand both the process being used [in this case, the state's leadership initiatives] and specific factors that led to the identification of the theme or conceptual label chosen (Knalf and Howard, 1984; Koch, 1994). These processes and factors were analysed using thematic content analysis (Strauss A, 1987),

through which I determined some broad categories under which each of the pieces of data would fit.

Results

A Opportunity and support for midwifery leadership

I approached the secondment with an understanding that as the Project Officer, I was required to facilitate a collaborative process for the development a five-year strategic plan for maternity services for the State. There was an advisory group of nominated representatives from key stakeholder groups, as well as health policy personnel with whom I worked. I had several additional performance objectives within the role, including a contribution to midwifery workforce planning, and increasing the numbers of student midwife placements available across the state, as well as broader policy directions related to the recruitment and retention of midwives. The senior nurse in the health department, to whom I was responsible for my work, provided an excellent role model for leadership. As a skilled political leader and bureaucrat, I learnt significant skills from her in relation to introducing change at the broader 'systems' level. The importance of effective listening, choosing one's timing wisely, ascertaining accurate facts and evidence, negotiation and consultation, and managing change at a strategic and political level, were all skills that were enhanced whilst I was in this role, under her leadership.

Her understanding for, and recognition of, the midwifery contribution to maternity services were significant. Unlike many of her senior nursing leader colleagues at the time, she was able to put aside her philosophical belief [that midwives were nurses] and listen to the arguments that midwifery was indeed a profession in its own right. I witnessed her change her language to be inclusive and to make more visible the role of the midwife. From the very early days of working with her, I only ever witnessed her speak of 'nursing AND midwifery', 'nurses AND midwives'. This was an overt expression of support and respect for my role and contribution. I have no doubt that this placed her apart from many nurse leaders and potentially in conflict with some of them. However, she never moved from this stance. The explicit statement of recognition of midwifery, from the state's most influential nurse leader was a powerful message to the nursing profession and also to [what was becoming] a more visible and midwifery profession. This was a political act at the time, and since then [1998], until the present time, an increasing number of nurses and midwives have begun using the more inclusive terminology. The sequelae to this are

further elaborated upon in the conclusion of Section 2 of the portfolio – Changing Structures: Reforming Midwifery Legislation.

B. Engaging consumers and key stakeholders

From the outset in the role as Project Officer, I sought to influence the structures and processes that would be used to develop the maternity services strategic plan. I believed that it was important to get the process as 'right' as possible, not only so the plan would be more relevant and useful to the majority, but also so that it would withstand any criticisms of not being 'relevant', 'applicable' or 'achievable'. Given the experiences of the earlier consultancy work, I knew that engagement of all of the key stakeholders was important to the end result, the report and plan, and to the ongoing implementation of the recommendations it contained. Membership of the steering committee was therefore an obvious starting point to achieve this 'process' outcome. Key stakeholders of women, midwives, GPs, obstetricians, independent midwives, representatives from Aboriginal health services and policy leaders, were among those invited to participate in the advisory committee. The principle of gaining consumer involvement early, and ensuring ongoing contributions, was upheld and anecdotally, was identified subsequently as one of the report's strong points.

C. Authoritative leadership for change

The Maternity Services Advisory Committee was subsequently formed, and at the direction of the health minister, was chaired by the most senior medical health department official. With a public health background, it was clear that he understood and was committed to, the principles [of primary health care] that we sought to implement. His formal position, high status and authority within the health system ensured that any innovations and changes recommended would have the support of the health department. It was my belief that his impartial leadership and authority, combined with the high degree of clinical credibility of the committee members (each individual being appointed in name by the Minister for Health), gave the report a legitimacy that enabled it to withstand any challenge.

Throughout 12 months of regular meetings, and phone and email communication, significant debate and many challenges occurred. This took place within an environment of increasing mutual respect and trust between the committee members. As time passed we grew to know each other's particular views, perspectives and interests. Substantiation of assumptions, critiquing of evidence, debate and inter-professional conflict and many philosophical differences all

featured within the committee at various stages. Nonetheless, there was a commitment to completing the task and developing a plan that would be meaningful, relevant and valuable in its contribution to improving maternity service provision.

Through this highly interactive and challenging collaborative process, I had the responsibility to write the final report known as 'The NSW Maternity Services Framework' (Appendix D). The report recommended a range of strategies and initiatives that reflect international and national policy developments in maternity care, including a greater role for midwives within mainstream services. Informed by evidence and underpinned by a strong commitment to primary health care principles, it was endorsed as the five-year strategic plan, and released into the health system in March 2000 (NSW Health Department, 2000b). The principles and priorities for maternity care identified for adoption across the State, reflected core values and philosophical principles of public health care including a focus on increasing overall health gain, consumer choice, equity of access and equity of outcome. These principles were the same as those that I [and others] had sought to introduce almost twenty years earlier, in the small 'cottage' maternity unit.

Thus, in one state in Australia at least, midwifery was becoming more visible in policy and planning. This occurred through the combination of recognising the evidence basis for midwifery, the collaborative and consultative efforts of a multi-disciplinary team, and skilled leadership of the chairperson. Within the work of this committee, the significant role and contribution that midwives can make to improve maternity care outcomes, was examined closely. Once the group as a whole accepted this I perceived a greater emphasis on collaboration and inter-disciplinary teamwork. Subsequently, this principle became incorporated as a theme through many of the strategies recommended in the report. In the process, the capacity and commitment of state health departments to develop evidence-based policies and plans for maternity services, through sound leadership and collaboration, was demonstrated

The report provided a framework from which area health services could review and further develop their maternity services. Anecdotally, the report was well received and seen as a useful plan. Rate of uptake and implementation of its recommendations varied. At the time of writing, three years since the report was released, it has remained the key strategic planning document for the ongoing development of maternity services.

D. Consensus through collaboration

Over the 12-month period of developing the maternity plan, the advisory committee made significant progress, negotiating agreement on the key issues. As stated earlier, this was achieved over time, as respect and trust grew within the group. The committee's structure and processes proved very effective. They ensured a commitment to adequate time for debate and discussion, clarification of information and evidence, and ultimately, the attainment of consensus. This was achieved due to a number of factors, in addition to the skill and authority of the chairperson, discussed earlier. It was my perception that the level of consensus reached, in particular around some of the more controversial issues, was the result of effective leadership and collaboration on several levels.

One example of the many challenging debates occurred around the decision to support the consumer's right to choose homebirth. The chairperson conducted the meetings in a style that expected consensus and clear outcomes from each meeting. Prior to the meeting, he and I would meet to clarify progress and any outstanding matters. Together, we would ascertain any problem areas and identify strategies to put to the group that might assist the process of moving forward. This often included the provision of information, such as additional evidence or other reading material, to update knowledge for people and further enhance the debate. In addition, he showed his skills in allowing enough time for a process to unfold, discussions to be had and decisions to be reached. Individual stakeholders [consumers and the representatives of the various professional groups] were all able to represent their constituents in an informed, articulate manner that reflected their leadership qualities. They were also able to share a commitment to the end result with others on the advisory group.

Conclusion to Case Study Three

The third Case Study has involved a review of experiences of leadership concerned with the development of state wide maternity service policy and planning. I have explored and analysed practical experiences of leadership that were designed to increase the recognition of midwifery in health services policy development, and improve the effectiveness of maternity services across the state. Through skilled leadership, and the collaborative processes of the working party, in drawing from current evidence and primary health care approaches, increased recognition of the benefits of midwifery within policy emerged. This provided the foundation for a range

of goals, objectives and strategies with the potential to improve models of care and service provision.

Many of the practical aspects of leadership and collaboration within the group sought to incorporate evidence about the contribution of midwives into maternity services policy development. The processes and interactions that occurred throughout the twelve month period was, anecdotally, reported as 'educative' and 'enlightening' for many of the committee members. Over time, and as respect for each other grew, we developed a number of beneficial processes of 'mutual influence and coalition building' (Burns, 1978). Through this, we were able to exchange ideas, views and experiences in ways that were mutually beneficial, as well as valuable to the policy development process.

The final 'Framework' was released in March 2000 (Appendix D). It was generally well received and has formed the basis for Area health services' developments and plans since then. The report reflected the need for collaboration and consultation to occur between service providers and consumers locally, to better determine needs and priorities and ensure that services are safe, efficient and effective. In addition they sought to see services that were respectful, personalised and rewarding for both consumers and providers of maternity care. This emphasis reflected the leadership of the working party and the improved relationships that, over time, developed amongst the stakeholders in the group. One of the key outcomes from the processes of engagement and discussion within the group was increased knowledge and recognition about the role of midwives. The 'Framework' reflected this and stands as an example of how leadership and collaboration can assist in addressing the lack of visibility of midwifery at a strategic policy development level.

3.4 CONCLUSION TO SECTION ONE

In this section, three case studies were used to describe a range of different characteristics, attributes and contexts where leadership in maternity services was either evident or sought. They are original and have emerged from practice and experience in the field. Each one was designed to highlight different experiences across contrasting settings in order to enhance understanding of how lack of an authoritative voice for midwifery is played out in the development of maternity services in general, and attempts to introduce midwifery models, in particular. They identify and offer some interpretation of how effective leadership can increase recognition of the contribution that midwives can make within maternity service provision. They also, to some extent support the earlier proposition that competent, well-informed midwifery leadership and effective collaboration is needed to enable significant change to occur.

One of the key principles that have emerged from the case studies is the importance of effective structures to support and enable leadership. Across each different context, the necessity of getting an appropriate structure that then allowed a process to unfold, was a critical first step. Examples of this included the importance of the membership of the various committees. Without the right structure and processes very little would have been achieved. As this became clear, the understanding of the capacity of individuals (traits and characteristics) emerged as important factors in effective leadership. The nature of the relationships and the processes of communication that reflected the power and status of individuals emerged later. These were additional factors that were highly influential in contributing to the success or otherwise of affecting changes and or improvements in policy or practice.

A hypothesis emerges from these case studies, which is that there is a lack of leadership in midwifery, and that the consequences of this are a lack of realisation of the potential for midwifery within contemporary maternity services. In determining how midwifery leadership contributes, or impedes progress in developing systems and models of maternity care, it is important therefore to explore theories and understandings of the various characteristics of the leaders. In addition, the specific attributes and features of the organisations, and contexts for leadership, such as those described throughout these cases, are also important to understand.

It is axiomatic that leadership is contextual and as such it is neither useful nor possible to provide an exhaustive critique of the comprehensive body of literature on leadership. Rather, I have searched extensively for literature that will inform and

explain the experiences described through the case studies and illuminated across different contexts. Whilst much of the leadership theory seems hotly debated, it is clear that an understanding of what makes a good leader, and what are the most important tasks of a leader, are critical to addressing the urgent need for effective leadership in maternity services.

The various leadership theories and traits are examined in detail in Section Three, through a review and analysis of the relevant leadership literature that arises from business, marketing and organisational psychology theories. In identifying key influences and characteristics of leadership from the contemporary literature, I apply these in an effort to enhance understanding of leadership in maternity services.

In doing so, I have done as Collingwood (2001) recommends and broken through my old habits of thinking and uncovered fresh solutions to perennial problems (Collingwood, 2001). In urging a breaking through of personal and interpersonal barriers, this author highlights the need for a fresh look at leadership and authoritarian management approaches (Collingwood, 2001). This is, in my view, exactly what is needed for improved maternity services policy development and planning in the future.

Effective leadership that promotes midwifery, whilst enhancing collaboration between midwives, doctors, managers and others, will require a redistribution of power, authority and responsibility if maternity services are to change and reflect the needs of women and communities. Current recommendations for change will not be successfully implemented without recognition and attention to this fundamental component of relationships between health care providers. These relationships and power structures are explored theoretically in the final section of the portfolio.

Enhanced leadership capability in midwifery is arguably, essential, in order to support and influence the necessary development and improvement of maternity services, and the growth of the midwifery profession. Findings from these case studies and the ensuing theoretical discussion will assist in the implementation of multiple strategies to assist the profession, policy makers and service providers in Australia to increase midwives' contribution and improve the care of Australian women.

In the following section, the implementation of several leadership initiatives are described and analysed. These arose from experience and practice, and developed in response to the identification and defining of the actual problem of invisibility of

midwifery. It is proposed that these techniques may effect an improvement in the recognition of midwifery, and address some of the concomitant problems with maternity service provision.

It is clear that multiple actions will be necessary to achieve change and redevelop the role of the midwife and a 'new midwifery' in Australia in the long term. In Section Two that follows, I describe some particular actions that I undertook as part of the leadership challenge to make midwifery visible.

4.0 SECTION TWO – TECHNIQUES TO MAKE MIDWIFERY VISIBLE

4.1 INTRODUCTION

This section of the portfolio reports the implementation of several strategic actions that flowed on from the identification and defining of the actual problem of invisibility of midwifery. It is proposed that these actions may effect an improvement in the visibility of midwifery and address some of the concomitant problems with maternity service provision

The first action consisted of a strategy aimed specifically at reforming the legislation and regulations governing the practice and education of midwifery in one state of Australia, that is New South Wales (NSW). This involved the preparation of a submission to the Review of the Nurses Act 1991 in which I, as the lead author, argued the need for greater visibility and recognition of midwifery within legislation. The process of leadership that was used and the outcomes of the submission and their implications for the midwifery profession are discussed.

The second action involved a strategy of leadership of the profession of midwives as members of their professional organisation, in one state in Australia. Partly in response to some of the findings in the 'midwives' voices' study, this strategy consisted of regular President's reports, designed to encourage and stimulate midwives to seek greater visibility and recognition.

The third action was the testing of a potential solution to the problem of midwifery invisibility through the application of some lessons learnt from both practice and from the empirical studies. This strategic action of leadership sought to build collaboration amongst maternity care providers and increase the potential for improved outcomes of care. Through an understanding of some of the theories of leadership and collaboration, this example of leadership in action is used to demonstrate a practical example of collaboration in maternity care and the concomitant potential for raising the profile, status and professional capital of midwives.

4.2 CHANGING STRUCTURES: REFORMING MIDWIFERY LEGISLATION

ACKNOWLEDGEMENT *A Legislation Sub-Committee of the NSW Midwives Association (Inc.) prepared the submission on behalf of the Executive Committee and membership of the Association. I was the lead author on this submission, working in collaboration with a group of midwives who shared a commitment to changing the regulation in order to gain greater recognition of midwifery. These midwives were Hannah Dahlen, Carolyn Hastie, Ann Grieve and Sally Tracy. I completed the writing of drafts, consulted with other members of the Executive Committee and wrote the final document. The submission continued as the primary document for ongoing discussions with the Health Department over a period of three years.*

4.2.1 Introduction

The analysis of midwifery regulation that was reported in Section One, demonstrated a number of serious inadequacies in both the standards of regulation, and the lack of clear recognition of midwifery in Australia. In each state and territory in Australia, midwifery is a part of nursing and is therefore regulated through a Nurses Act.

In mid-1999, the NSW Health Department announced a review of the Nurses Act, which provided us with an opportunity to raise issues of serious concern, and identify the changes required for midwives in NSW. Since the passage of the previous Act in 1991 in NSW, midwives who were active in their professional Association had been seeking changes to the regulation of their practice and education. In particular this was in regard to seeking recognition distinct to nursing.

In this section I will provide an illustration of the strategic action developed as part of my leadership role as President of the Association. This involved the formation and leadership of a working group to prepare a submission to change the current Nurses Act and seek greater visibility of midwifery.

4.2.2 Aim

The aim was to implement a deliberate leadership strategy to increase the legal recognition of midwifery in NSW through a submission to the Review of the Nurses Act 1991.

4.2.3 Method

The approach used was exploratory which involved the gathering of all the relevant documents and government reports related to legislation and regulation of midwifery, from state and national sources as well as those from the United Kingdom, Canada and New Zealand. A total of eighteen separate documents and reports were reviewed. These were analysed to determine the nature of regulation in other similar countries and to identify some useful frameworks to approach the review process. I then formed a working group, which consisted of midwives who had, for many years, been vocal about the need to change the Act, and several current members of the Executive Committee of the professional Association. As the President, I convened the first meeting and together we determined a plan and agreed process for advancing the work to be done.

The NSW Health Department had distributed an 'Issues' Paper (NSW Health Department, 1999) and contained within this was a specific format for providing submissions to their Review. This format meant that we were required to insert our responses under particular headings, which followed short pieces of explanatory text designed to inform and educate the reader and clarify points of fact. This limited the amount of discussion of the issues we could provide and ensured that we made our arguments very 'tight' and focused within the format.

At the outset, two members of our working group held strong views that the submission should push for a separate Midwives' Act. Three others, including myself felt strongly that the most strategic move would be to pursue a 'nurses and midwives' Act which, from our reading of the political milieu at the time, would be as much change as the health department would consider. We debated and argued these issues for some time and ultimately our strategy became two pronged. We agreed that the direction of the submission would be towards a nurses' and midwives' Act and that, as individuals, they could also choose to lobby separately for a midwives' Act. Such an approach was deemed to make our move less radical, more acceptable and more likely to succeed.

The working group of five of us met on three occasions and corresponded frequently via email as needed. We debated and negotiated until we reached consensus on the various issues that arose in the Review. I prepared the draft paper in consultation with them, and took responsibility to see it through to its completion and formal submission to the Department of Health by the due date.

The submission was put forward in October 1999. It will be presented here in an abridged form within the format required by the review process. For this section of the portfolio, only the relevant discussion points are selected, these are in italics followed by our responses. This is provided to demonstrate the key arguments that we made with regard to addressing the need for greater visibility of and recognition of midwifery within regulation. The full submission can be found in Appendix E.

4.2.4 Results: A Review of the Nurses Act 1991

Selected discussion points and responses of relevance to this thesis have been extracted from the document for inclusion here, as follows:

DISCUSSION POINT 1

Does the above discussion adequately set out the scope of the market for nursing services? Are there occupational groupings that are affected by the provisions of the Nurses Act, which have not been considered?

The discussion in Part Two does not adequately set out the scope of the market for midwifery services. Direct entry midwives who come to NSW and seek to be registered are currently inappropriately required to register as a nurse, even they do not have approved qualifications. This is an anomaly in the Act and must be corrected. This is misleading, inaccurate and misrepresents the particular skills and abilities of midwives. This has implications for employers and is not protecting the public.

The practice of midwifery or nursing is not defined in the Act. If they were to be defined we would recommend that the definitions be flexible and not restrictive of the broad 'scope' of midwifery and nursing practice. This will expand the scope of the market for midwifery services by allowing for midwives who are not nurses to be registered in NSW.

DISCUSSION POINT 2

Should lists A and B of the Register and/or Roll be merged?

Submissions arguing that separate lists should be maintained on health and safety grounds should specify the benefit to the public health and safety of maintaining separate lists.

We recommend separate registers for midwives and nurses. The skills and practices of each profession are distinct and different. The public has a right to this information and a separate register is legal recognition of the difference in the professions. A separate register protects the public. It is not appropriate to have a nurse provide midwifery care. Having a separate register for the professions ensures that there is no confusion regarding the role of nurse and midwife. Two registers would ensure that those that had both professional qualifications were recognised as having completed both educational pathways. Some nurses may also need to work as midwives and thus would require being on two registers. Given the current workforce shortages it is important that requirements for both lists should be sufficiently flexible not to reduce our potential pool of registered midwives and nurses. The excessive medicalisation of childbirth has diminished women's control over their reproductive experience and led to unacceptably high incidences of intervention and operative births. This is a public health issue of great importance. Research has demonstrated clearly that women want more humanised care, less intervention and more control (Biro and Lumley 1991; Brown and Lumley 1994). Studies have shown that midwifery care provides the sort of care that women want and that also improves health outcomes (Flint and Poulengeris 1989; Harvey et al 1996; Kenny et al 1994; McCourt and Page 1996; Rowley et al 1995). New models of midwifery care are being developed, models, which demand a primary health care approach and greater responsibility and autonomy for midwives. The changing role of midwives and the rapidly expanding professionalism of midwifery require a legal recognition of the role and profession of midwifery. A separate register for midwives and changing the name of the Act to the Nurse's and Midwives' Act is essential so that legislation keeps pace with reality of contemporary maternity care.

DISCUSSION POINT 3

What are the objects of the Nurses Act and do they remain valid? Comments on the desirability of including in the Nurses Act a statement of its objectives are invited. Submissions in favour of this proposition, which canvass the content of any objects clause, would be particularly welcome.

The purpose of the Act is to protect the public from unsafe practice and to provide a forum for consumers to bring complaints regarding unsatisfactory care to the attention of the Board.

The board's objectives are to provide:

- Mechanisms to protect the public against incompetent practice, unsatisfactory professional conduct and the recognition of level of impairments amongst nurses and midwives
- Mechanisms to ensure the provision of advice to nurses and midwives about matters relating to professional competence and conduct and identification of levels of impairment
- Mechanisms to remove from the register those nurses and midwives whose practice, conduct or level of impairment is found to be unsatisfactory.

The professional bodies for midwives and nurses provide:

- Mechanisms for the accreditation of midwives and nurses
- Mechanisms to ensure that professional standards are maintained at an acceptable level and,
- A framework for educational programs.
- Any revision of the Objectives should add the words 'and midwife/midwifery' to all references of 'nurse/nursing'.

DISCUSSION POINT 4

What evidence is there to support the need for regulation of practitioners providing nursing services? What is the impact of the current restrictions on competition?

Midwifery and nursing should both be regulated for the protection of the public and maintenance of public trust and confidence with the professions. We believe that it is time for midwifery to be identified separately within the Act in recognition of the unique contribution that midwives make to optimise

maternity health outcomes. Wherever there is a strong and autonomous midwifery profession, there is a powerful advocacy for women and women's choices in childbearing issues (Guilliland and Pairman 1995; Katz-Rothman 1991). Countries such as New Zealand, Sweden, Holland and the UK all have statutory regulation of midwifery and enjoy improved maternal and neonatal outcomes and are experiencing a proliferation of midwifery models of care (Department of Health 1993). These phenomena are directly related. Therefore to protect the public, a strong, autonomous regulated midwifery profession is necessary.

DISCUSSION POINT 6

Should there continue to be regulation of midwifery? If so, what is the most appropriate form of regulation? If it is considered that regulation should be by title and core practices, what core practices should be restricted? If it is considered that regulation should be by title and whole of practice, what should the definition for midwifery be? Should the Act continue to provide exemptions for certain categories of persons from the restrictions on the practice of midwifery? If so, which categories of people should be exempted and what should those exemptions be? Submissions arguing in favour of restrictions, whether they are on title or on both title and area of practice, should provide evidence of risks to the public and that restrictions are therefore necessary in the interests of public health and safety.

The most appropriate type of regulation at this time, for the midwifery profession, is self-regulation through a Nurses and Midwives Act. Midwifery has long been recognised as a discipline distinct from nursing in other countries. The practice of midwifery was regulated in the UK some seventeen years before the registration of nurses, as a result of the concern of medical practitioners about unqualified birth attendants. The current UK registration statute is titled the Nurses, Midwives and Health Visitors Act, which recognises the different disciplines. This legislation was recently reviewed and the report is recommended to NSW Health in its deliberations (UK Health Departments and JM Consultancy Ltd 1998). It is significant that this major review of the Act in the UK highlighted the need to "ensure that the public protection afforded by the Act is effective while not stifling developments in health care' (p6). Like at no other time in Australia there is an extensive amount of public health reform, restructuring of services and developments of new models of maternity care that are emphasising the unique benefits and

potential of midwives as health care practitioners (NHMRC 1996 and 1998; NSW Health Department 1989 and 1999).

Joint regulation of nursing and midwifery with full participation from both, gives due recognition to the profession of midwifery in Australia and will bring us into line with other Western countries. Recent changes in legislation in New Zealand have seen midwifery recognised as an autonomous profession, distinct from nursing.

The two professions of nursing and midwifery differ in their practice and education, but they share common values and principles that mean that they can effectively come together in the public interest for the purpose of statutory regulation. We should work together on the principles, standards and mechanisms to regulate our education, practice and professional conduct whilst retaining our distinct areas of practice, education and professional bodies. Together we can respect and learn much from each other.

Such an alliance will ensure 'profession specific' issues are addressed by the relevant group along with the involvement of all key stakeholders. Policy and strategic directions for both professions would be developed jointly, to the benefit of both, whilst ensuring that neither profession is dominated or dictated to by the other. To reduce excessive infra structure costs associated with two separate regulatory bodies, a change in the title of the Act to the 'Nurses and Midwives Act' would appear the most appropriate amendment to the legislation.

We believe that regulation should be by title and scope of practice and the scope of midwifery practice encompass the following:

Midwife means 'with woman'. A midwife is a specialist who has been educated to provide midwifery care to childbearing women (and families). This includes pre-pregnancy counselling, antenatal, labour and postnatal care, referring to other health professionals as appropriate. The scope of practice of a midwife should be aligned with the Australian College of Midwives (ACMI) competencies of the midwife (1998).

Protection of title is an important element in protecting the public and this should apply to midwifery. This would make it unlawful for anyone other than registered midwives to hold themselves out to be a registered midwife. This is

most important in contributing to the public's perception of the distinction between the professions of nursing and midwifery and enhances their 'informed choice' around maternity care. The objective of title restriction is to protect the public by ensuring that consumers are able to identify qualified persons. The public need to be aware if they are receiving care from a midwife, or a nurse or a doctor. It is noted however that protection of title is of little importance unless the public are educated to understand the significance of the title and are able to understand the Act.

We recognise that within the current workforce shortage crisis there is considerable difficulty in restricting the practice of midwifery to midwives only. In addition, we recognise that certain aspects of the care provided to women includes a range of skills and tasks that can be performed by others who are trained to do so in their chosen discipline. Examples of these skills include: recording of blood pressure, assisting a woman to breast feed her baby, recording of medical history etc. What is unique to midwifery however and what identifies it as separate from nursing and medicine is the 'continuity' of skills and care across a spectrum of time in a woman's life. There is considerable evidence to support midwifery continuity of care as the cornerstone of 'best practice' in maternity care (Brown and Lumley 1998; Hodnett 1996; Oakley et al 1996; Page 1995; Rowley et al 1995; Tew et al 1991; Tucker et al 1996; Turnbull et al 1996). The 'continuum' of care and practice, which is unique to midwifery, involves antenatal care, all of labour and birth care and the post partum period. Central to this 'continuum' of care is 'the relationship' that develops between a woman and her midwife that has an impact on health outcomes and morbidity (WHO 1996).

Continuity of care and social support during pregnancy and childbirth are critical factors in improving women's maternity health care outcomes and they are linked to long term health gain (Oakley et al 1996). Within the concept of continuity of carer, this relationship is different from any other relationship that involves health care workers.

We recommend that only suitably qualified and registered midwives have overall responsibility for midwifery care and as such midwifery practice should only be performed by non-midwives under the supervision of registered midwives who are in current practice. Maternity care provided to women by medical officers is not midwifery and as such does not fall into this area of

regulation. The newly named 'Nurses and Midwives Board' must involve the midwifery profession in articulating the exact nature of 'supervision' to determine an appropriately clear articulation and meaning of this term. This is critical to the review of the Act in order to protect the public from unsafe care, ensure employers are able to provide appropriate personnel and also to ensure that midwives maintain responsibility for midwifery care and practice.

There is a long history of midwifery being subsumed into nursing in this country, with disadvantages to both midwifery and the public. Midwifery has not had a strong voice in the corporate health-planning sector. Senior nurses have been required to represent both nursing and midwifery with a natural tendency towards nursing being dominant. This has meant that despite all the evidence linking improved maternal and infant outcomes with strong autonomous midwifery practice, such practices have not flourished. There are numerous studies and government reports that recognise the necessity for midwifery models of care to reduce associated costs associated with high levels of intervention and morbidity for women in childbearing. (DOH Victoria 1990)

The recommendations for and recognition of a necessary reorganisation of the way that maternity services are provided will mean a restructuring of the midwifery profession, including a new and fresh approach to educating midwives (Baldwin 1999; Page 1993). Many nurses have been educated as midwives and have never practised midwifery. This is inefficient and wasteful of resources. Direct entry midwifery education is recognised internationally as the most appropriate way of preparing midwives to work in the new models of care. Tertiary educational organisations across Australia, in recognition of the shift to more effective models of midwifery care, are developing innovative collaborative approaches to midwifery education that include a three year Bachelor of Midwifery (Direct entry midwifery) (Leap 1999). It currently takes five years (minimum) to educate a midwife via the nursing route. It is counter productive and a waste of resources to insist that all midwives must be nurses.

If NSW is to attract more midwives to redress the shortage of midwives, it will need to recognise that other countries, for example UK and New Zealand, have instituted direct entry midwifery programs through which it is possible to become a midwife without having studied nursing first. Recruitment to such

programs appears to be very successful, and such a strategy might address some of the midwifery recruitment problems being currently faced in NSW.

DISCUSSION POINT 8

How should competency be assessed? Is the current range of qualifications recognised by the Board appropriate? Should the process used by the Board to accredit educational programs be changed and if so, in what manner?

Is there any evidence that competent people are prevented, by the Board's accreditation criteria, from practising nursing?

Currently there is a huge discrepancy and disparity between midwifery educational programs across the country. There needs to be extensive national review and consultation to determine what is an acceptable national standard for midwifery education. The attainment of internationally recognised standards would enable Australian midwives to work in other countries without having to complete further studies or clinical experience.

The NSWMA should be given a greater role in the accreditation of midwifery educational programs and we recommend adoption of the Australian College of Midwives (ACMI) competencies of the midwife (1998).

One of the emerging concerns within current maternity care provision is that of Indigenous women's maternity care. With particular reference to rural and remote areas, we are aware of birthing practices and services on the homelands provided by traditional birth attendants (TBAs). It is possible that these people may be competent and, under the act, are practising illegally. Regulation of the practice of registered midwives does not restrict the number or practices of unregulated health care workers who may be practising certain aspects of midwifery. Given the poor health outcomes for Indigenous people (AIHW 1998; Day et al 1999), and recommendations for models of care that promote the involvement of Aboriginal Health Workers (National Aboriginal Health Strategy 1997), this issue needs special consideration. We seek the opportunity to work closely with the new Board to develop strategies to address this important challenge.

DISCUSSION POINT 14

What strategies should be adopted, if any, to ensure that nurses remain competent to practise? Is there any evidence that nurses are failing to maintain standards at an

appropriate level and that consumers are thereby exposed to harm? Should the Board have the power to refuse an application for restoration and if so, on what grounds? The advantages and disadvantages of any strategies advocated should be discussed.

The issue of recency of practice is a complex and important issue. The current shortage of midwives necessitates the preservation of every midwife available. This does not address issues of quality or competence. There is an argument that as professionals in their own right, midwives and nurses should be self-regulating. There are multiple considerations that will require exploration through a collaborative approach with key stakeholders. In the long term we believe that a recency of practice requirement in the legislation is important and that this should reflect a national standard. A national standard will allow for the mutual recognition of accreditation from other states and territories. With regard to temporary and provisional registration, this can be linked to the recency of practice issue. For example, in one state, midwives may continue to be registered annually, but require a current 'authority to practise' if wishing to provide direct clinical care. In another, they must sign that they have maintained competence and have determined for themselves that they are safe to practice. Such an arrangement may address some of the concerns of dedicated midwives working in fields other than direct clinical care. It would however raise the complexity of issues surrounding refresher and re entry programs including who provides them, as well as costs, content, standards and quality.

We acknowledge the paucity of evidence to demonstrate a concern regarding standards of, or complaints about midwifery care, but do not believe that this is necessarily an indicator of high standards of professional competence. The NSWMA has considerable anecdotal evidence that highlights concerns with fitness to practise amongst some midwives and also 'fitness' to be in the role of supervising non-midwives, especially in rural and remote areas and in those areas with midwifery staff shortages. Whilst self-regulation is the ideal for any profession, there is a diversity of opinions that need to be exchanged and explored so that there is an understanding of what constitutes a reasonable level of competency amongst midwives.

The Australian College of Midwives has already gone some way toward establishing some means of measuring the individual's commitment to

ongoing education with the development of the Professional Development Credit Point (PDCP) system. The PDCP system enables midwives to maintain a record of continuing professional education undertaken, with each educational opportunity being given a numerical value according to its content and the credentials of the presenters. It can be reasonably expected that the average midwife will accumulate 40 points in any one-year period, although the potential for much more is there. This system, together with the ACMI Competencies, Code of Practice and Code of Ethics could form a basis for discussion of the need (or otherwise) for compulsory continuing education for midwives. We therefore recommend that the Nurses and Midwives Board in partnership with NSWMA (the state branch of ACMI), explore these as well as the international systems and mechanisms for maintenance of midwifery standards to determine what constitutes appropriate professional activity and the best way forward regarding policy on this crucial issue.

DISCUSSION POINT 11

Should the Nurses Act incorporate the mutual recognition of accreditation from other States and Territories?

Once the national standard for recency of practice and educational standards are set, the Nurses and Midwives Act should incorporate the mutual recognition principle of accreditation from other States and Territories. The adoption of mutual recognition principles within accreditation procedures would allow for direct entry midwives from other countries to register in NSW.

DISCUSSION POINT 19

Should chairs of Professional Standards Committees be required to have any particular qualifications or experience?

We believe that the chair of the Professional Standards Committees must be legally qualified and have extensive understanding of the issues under review.

DISCUSSION POINT 20

Comments on the desirability of creating a more structured mechanism for appointing members of the panel of laypersons to sit on Professional Standing Committees (PSCs) and the Nurses Tribunal are invited.

Consumer membership on the Board is essential. Submissions of interest should be called for when considering consumer representation. The person(s) ought to be required to submit an application, resume and a statement of interest and also attend an interview with members of the Board and some of the key stakeholders, for example the Chief Nurse, Chief Midwife, and or representatives from professional bodies, to determine their suitability and reason for interest.

DISCUSSION POINT 21

Comments are invited on the composition of PSCs and the Nurses Tribunal. Should members of the Board be precluded from sitting on PSC s and Tribunals?

Yes, Board members should be excluded from the PSCs. Given that it is often a member of the Board that refers the matter to the Professional Standards Committees and Tribunals, members of the Board should be precluded from sitting on Professional Standards Committees and tribunals. It could lead to a conflict of interest or a potentially biased situation.

Clearly, it is essential that appropriate numbers of midwives sit on PSCs involving midwifery and nurses on those involving nursing, although these do not need to be mutually exclusive of each other. The Board will determine the exact composition and structure of the committee, however the development of some agreed principles around collaboration and recognition of boundaries of professional practice would seem beneficial. This should include a principle that neither profession can be out voted by the other on matters, which are specific to their profession.

DISCUSSION POINT 32

Submissions relating to the size and composition of the Board and the mechanisms, by which members come to be nominated for appointment to the Board, are invited.

The Nurses and Midwives Board's composition will require modification to reflect the joint partnership of the two professions. We recommend that the membership include 2 registered midwives, experienced and in current practice and a midwife representative of the NSW Midwives Association Inc. There is no justification for the NSW College of Nursing to automatically being given a place on the Board and if this continues to be so then a representative from the NSW Midwives Association must also be appointed.

4.2.5 Additional Comments to the Review

It is important that wherever 'registered nurse/nursing' is mentioned in the Act, that the Act be amended to include 'registered midwife/midwifery'.

The Act must be rewritten in a way that the public can understand it. Given that many nurses and midwives themselves cannot decipher the language and meaning of the current Act, it is reasonable to assume that many members of the community similarly cannot. Adoption of the 'plain English' approach, similar to that which is now used in most insurance and other legal documents that the public are able to access, would be a further improvement and contribution to informing and protecting the public.

4.2.6 Conclusion

This leadership strategy used the submission of a discussion paper to a state government to argue the need for greater visibility and recognition of midwifery within legislative structures. The 'process' of leadership that was implemented in order to increase the legal recognition of midwifery appears to have been effective on a number of levels. Many of the recommendations put forward by the NSW Midwives Association were included in the final submission to parliament from the state health department.

In the submission, we argued the need for a change in the view and legal positioning of the Board, in order for midwifery to be seen as distinct from nursing. We sought a number of significant changes in legislation and regulation that would give proper recognition to the unique contribution that midwives make to optimising maternity care outcomes. These included the need to develop separate registers

and standing practice committees for midwifery and nursing, as well as a change in name to the Nurses and Midwives Act. The new legislation also needed to ensure the establishment of separate standing committees: the Nurses Practice Committee and the Midwives Practice Committee. All of the recommendations put forward by our group, were incorporated in the Bill for amendment of the Act with exception of one.

On the evening of 16th September 2003, the Bill to amend the 1991 Nurses Act to become the 'Nurses and Midwives Act' was passed through the Upper House of the NSW Parliament (NSW Legislative Council, 2003). The Act will be administered by a newly formed Nurses and Midwives Registration Board. During the historical [for midwives] parliamentary session, a Democrats Senator, the Honourable Dr. Arthur Chesterfield-Evans, took the opportunity to pay tribute to some of those who had campaigned for midwifery to be recognised within a new Act, stating:

"I acknowledge and congratulate the following people for their good work and advocacy over the years: Pat Brodie, President of the New South Wales Midwives Association; Jan Robinson, the National Co-ordinator of the Australian Society of Independent Midwives; Denise Hynd and Virginia Miltrup from the Maternity Coalition".

(NSW Legislative Council, 2003)

This significant move forward, and the ensuing processes of developing a more appropriate and effective regulatory system should, at least in one state of Australia, assist in gaining legal recognition of midwifery. This will better protect the public and assist the profession in sharpening its focus on the development of appropriate midwifery standards for practice and education. Clearly, it will also assist in informing the public and enabling midwifery to be visible and distinct from nursing.

Additionally, as discussed earlier, it was during this period [when the Bill was being prepared] that the senior nurse leader in the state government changed her language to include [and recognise] midwifery when discussing and writing about nursing. Such overt recognition for midwifery was a powerful message to the professions of both nursing and midwifery. In mid 2003, albeit under the leadership of a new Chief Nurse, this branch of the Health Department [Office of the Chief Nurse] changed its name to 'Department of Nursing and Midwifery'. At about the same time, the industrial organisation for midwives [the NSW Nurses Association] agreed at their national conference, to change the nomenclature of all awards, pay

scales and policies to include the nomenclature 'midwife' and 'midwifery'. All of these actions herald a new era for midwives in this part of Australia and will assist in addressing some of the barriers to midwifery that have been identified earlier in the portfolio.

The significant structural changes described here will strengthen the organisation and regulatory systems, so that midwives are more recognised and able to provide a full and legitimate role in maternity care in Australia.

In the following section the second strategic action of leadership as a process, is described and interpreted. This was designed to engage the profession of midwives who were members of their professional organisation, in one state in Australia. This strategic action involved the dissemination of regular reports from me as the leader, to the members of the Association. The reports were presented in the form of a 'call to action' to the profession as a process to engage with midwives, at a time when many challenges and potential opportunities for greater visibility [such as the one just described with the review of the regulation] were being put forward.

4.3 CHANGING PROCESSES: LEADING THE PROFESSION - A CALL TO ACTION

4.3.1 Background

The roles of researcher on the AMAP study, and advisor on policy development, enabled me to observe first hand the networks, positioning and inter-dependence of the various agencies and organisations that influence midwifery practice and maternity care. This included the opportunity to read and review a large volume of policy documents, strategic plans, regulations and reports, all of which were available in the public domain. I also attended a multitude of forums, meetings and discussions concerning midwifery and maternity services over several years.

Throughout the three-year research phase, both the chief investigator and co-researcher supported me to continue to actively engage in key midwifery 'leadership strategies' that were designed to make the issues currently affecting maternity care and midwifery more 'visible'. This included support for me to accept nominations both as the state president, and the delegate to the national executive committee, of the Australian College of Midwives. Through these roles, I was able to gain further experience in the formal position of a midwifery leader. Simultaneously, I could also gain insights into the role, attributes and responsibilities that were required in order for leadership to occur.

From these different positions, I met and interacted with key stakeholders who were responsible for midwifery policies, regulation, education and overall maternity service provision. I joined various working parties and meetings. These opportunities enabled me to observe and interpret a range of different approaches to leadership and collaboration in midwifery and maternity services development and review. These activities provided me with leadership opportunities, which complimented and enhanced the work I was able to do for the midwifery professional Association.

4.3.2 Introduction

In this section I describe and reflect on my role as President of the State branch of the professional body for midwifery. This involved the application of a number of techniques and strategies, which I adopted. As the nominated leader, I was in a position to influence and guide some of the political and strategic directions that were being developed for maternity services across the state. I was contributed advice and direction to peak bodies concerned with the role, scope of practice and

education of midwives. I was also responsible to lead and influence the members of the Association, the midwives across the state, who were engaged in practice. I did this through presentations at professional conferences, in the print, radio and television media and through writing to them each quarter as the President of the Association.

This technique of using leadership as a process was developed partly as a response to some of the findings in the 'Midwives Voices Study' and partly as a reflection of my own concerns for the profession. In the 'Midwives Voices Study' strategies were identified to address the lack of recognition and visibility, including the need for those in authority to 'show leadership and advocate for increased recognition of midwifery within the health system and the wider community'. Increasingly I was despairing for the future. This was related to what I perceived all around me and in various contexts, as the low status and lack of visibility of midwifery within society. It involved a lack of capacity to be 'heard' at any level.

I used the quarterly President's reports as a strategy, to provide leadership, ideas and motivation to the members, in the hope that this would encourage and stimulate them into action to achieve greater visibility and recognition. Along with a series of political media activities that included radio and newspaper articles (Appendix G), this strategy was designed as a 'call to action', to raise awareness of the issues and engage midwives and others in understanding and seeking ways of addressing them. A series of the president's reports is provided in Appendix F.

4.3.3 The President's Role

In August 1999, I was elected President of the NSW Midwives' Association, the state branch of the Australian College of Midwives Incorporated. At the time, some declared this as a 'fresh start' in the leadership of the Association. Members had expressed a stronger voice and higher leadership profile from the President. I had filled the role as vice president for the preceding two years and felt driven to take on the role and the challenge. This was because of an ongoing frustration and concern I felt with the lack of progress and achievement, most particularly in the area of political influence, status and representation of the midwifery profession. I had been an active member of the Association since 1979 when I joined as a student midwife and had been an Executive member for seven years.

As the President of the NSW Midwives Association, I provided a quarterly report to the members. Rather than presenting an inventory and reporting activities for the

three-month period, I chose to make these reports an opportunity for dialogue with the profession – a form of ‘call to action’. This was designed to engage with, influence, challenge, and stimulate them to think more broadly about the socio-political issues affecting their practice and their profession. In addition, I sought input and feedback from them about the key professional issues that were emerging at the time, namely regulation, workforce and educational issues.

4.3.4 Political Context

At the time of commencing the President’s role there was considerable political activity in NSW that had the potential to both challenge and change the profession. Legal recognition of Nurse Practitioners was imminent and changes to the Nurses Act were being considered. The international insurance crisis had emerged and led to the loss of professional indemnity for midwives. A high profile midwife was facing charges of professional misconduct and the media was using this to direct attention to concerns about safety in childbirth, especially homebirth or birth without doctors. A Commonwealth senate inquiry into childbirth practices was being conducted (Commonwealth Department of Health and Aged Care, 1999) and there were growing midwifery workforce shortages with various threats to close small rural maternity units. As such, I was immediately challenged with the responsibility to show leadership, authoritative knowledge and credibility for the midwifery profession in NSW. This required a high level of responsiveness, through written and telephone communication, submission writing and media work such as radio interviews and quotes in national newspapers. I was suddenly very busy. A sample of the range of media activities is listed in Appendix G.

4.3.5 Aim

The aim of this section is to report and analyse the effectiveness of a leadership strategy designed to engage with and provide leadership to midwives as members of a professional organisation.

4.3.6 Method

The strategic action was a demonstration of applied leadership within the midwifery profession, to raise awareness of the issues affecting the role of the midwife in the provision of maternity services. This was in the form of regular reports provided to midwives along with political activities that included radio and newspaper articles. These reports were timely, opportunistic and addressed the ‘issues of the moment’ as a way of drawing midwives’ attention and interest. The strategy was implemented

through my role as President of the New South Wales Midwives Association Incorporated ('the Association'). In this capacity, I purposely sought to influence, contribute opinion, and give a professional 'voice' for midwives. This took place over the period from 1999 to the current time in late 2003. As their nominated leader, I was required to provide direction and advice that would assist in the advancement of the profession, in order to ensure greater visibility, recognition and representation of midwifery and to improve systems of maternity care overall. Concomitantly, the reports also sought to educate and inform midwives and assist them in advocating for change in their own settings.

Conference and seminar presentations specifically designed to stimulate and motivate the profession towards greater 'visibility' and recognition within the systems of maternity care and the wider community across Australia also part of this strategic action. A sample of these presentations is listed in Appendix H.

4.3.7 Results

A series of reports were provided to the members of the Association every three months from the period from 1999 to September 2003. These were designed to show leadership, through the provision of knowledge and information, which could raise consciousness and stimulate political awareness. It was envisaged that this could potentially at least, assist the profession of midwifery in gaining greater recognition.

The reports were presented as a 'call to action' to the profession, at a time when many challenges and potential opportunities for greater visibility were being put forward. They were written to address 'issues of the moment', in that they were meant to draw attention to current issues that were identified and of potential concern to midwives. The titles chosen were deliberately 'catchy' in order to attract immediate interest in a way that regular reports from the president might not.

The reports were also intended to influence the thinking and planning of others who might read them, including the Chief Nurse and other leaders of industrial and regulatory organisations.

The reports are provided in Appendix F, as a set of published papers, arranged in chronological sequence to reflect the 'issues of the moment' that midwives in NSW were facing during the period from late 1999 to mid 2003.

Later, in Section Three, through the construction of an essay, I apply a theoretical interpretation of the insights and experiences of leadership and collaboration that have been illuminated through these actions to 'make midwifery visible'.

4.3.8 Conclusion

This section described a process of leading the profession utilising a strategy of written reports in newsletters, in the form of 'calls to action'. Through the practical application of theories of leadership, which draw on my own experiences and understanding of the literature, I sought to influence and engage midwives, on a number of critical issues affecting their practice and profession. The extent to which I was able to influence or engage has not been measured or evaluated for this portfolio. Anecdotally, the membership of the Association has risen consistently and attendances at conferences run by the Association have had increased numbers in attendance. Informal feedback, from individual members from various parts of the state confirms that they gain much from the reports, and the organisation as it is now functioning.

As discussed earlier, it was during this period that the senior nurse leader in the state government changed the nomenclature in all relevant government documents to include [and recognise] midwifery. Also the Office of the Chief Nurse changed its name to 'Department of Nursing and Midwifery'. This was happening as the industrial body for nurses and midwives decided to change the nomenclature of all awards, pay scales and policies to include the nomenclature 'midwife' and 'midwifery'. It is my view that all of the efforts to have midwifery recognised within nursing, including the Presidents reports and conference presentations by myself and many others, were all starting to have an effect.

The significant structural changes described here will, in the long term, strengthen the organisation and regulatory systems, so that midwives are more recognised and able to provide a full and legitimate role in maternity care in Australia.

The earlier sections of the portfolio confirmed the problem [of invisibility] and revealed that some of the barriers that exist to midwives' capacity and potential to make a major contribution to maternity care are in fact midwives themselves. It was anticipated therefore, that through the provision of written reports, I might inform, educate, challenge and raise awareness of current issues and assist midwives in developing a stronger professional identity of their own.

This was one of multiple strategies requiring overt leadership and guidance of the profession to ensure improvement, not only in developing the individual midwife's self concept, but in raising the overall capacity, potential and professional capital of midwives more broadly.

In the following section the third strategic action of leadership as a process, is described and interpreted. This will illustrate a test case involving the application of some of the principles of effective leadership and collaboration that were identified through the case studies.

This strategic action was my role as part of a major multi-disciplinary innovation in the education of maternity care providers in Australia: the introduction of the Advanced Life Support in Obstetrics ('ALSO') Course. This is used to demonstrate a practical example of leadership that promotes collaboration to achieve changes that may improve the outcomes for women who access maternity services, and also raise the profile and status of midwifery in Australia. It is presented as one example of what can be achieved when midwives and obstetricians join together in a shared endeavour that requires collaboration to achieve improved outcomes.

The case demonstrates a further example of the potential to increase the visibility and recognition of midwives through leadership. Developing effective inter-disciplinary collaboration and positive professional identities, networks and affiliations, may also improve the capacity and functioning of individuals, which in turn, can increase the 'professional capital' of midwives.

4.4 CHANGING OUTCOMES: COLLABORATING TO MAKE MIDWIFERY VISIBLE - THE 'ALSO' EXPERIENCE

4.4.1 Introduction

Following the completion of the strategic planning and policy work for the health department I returned to the teaching hospital environment and continued in the role of clinical midwifery consultant focusing on the development of midwifery models of care in the public system. In this section, I apply some of the themes that have emerged from analysing experiences of leadership in the three case studies, and use them to describe the implementation of an innovative approach to education and practice change. I will describe and analyse a specific leadership strategy aimed at improving maternity care through the combined processes of engaging the midwifery profession in making midwifery visible, and increasing the degree of collaboration amongst maternity care providers.

The leadership strategy was my active participation with others in the introduction of the multi-disciplinary educational initiative known as 'ALSO' (The 'Advanced Life Support in Obstetrics' Course) (American Academy of Family Physicians, 2000). In the years 2000 to 2002, I collaborated with another midwife, an obstetrician, and a risk manager to lead the introduction and implementation, of a two-day skill-based clinical course for maternity care providers. This process utilised midwifery leadership and high profile collaboration across maternity care to initiate, develop and implement the course across Australia. It is described here, as one example of what is possible when midwives and obstetricians join together in a shared endeavour that requires collaboration to achieve improved outcomes.

One of the major strengths of ALSO is that it can only be provided as a multi-disciplinary course. This is because networking and building relationships between the different professional groups are seen as critical components in the development of collaboration, communication and inter-professional trust. The opportunity to learn on an equal footing with others from a different professional background and the non-hierarchical approach of ALSO is deliberately designed to break down barriers that have been identified as contributing to poor outcomes in maternity care (Department of Health UK, 1998; Maternal and Child Health Consortium, 1998). Originating in the USA, 'ALSO' brings together clinicians from midwifery, obstetrics and perinatal care for training in the management of obstetric emergencies with a specific focus on risk minimisation.

The philosophy that underpins ALSO is that women and their families will benefit from the standardised, collegial and multi-disciplinary approach to maternity care that the ALSO course engenders. The course consists of several didactic presentations and small-group, hands-on workshops using life-like models. Participants learn mnemonics to trigger appropriate responses in emergency situations. The course finishes with a written knowledge test and a 'megadelivery' hands-on practical examination at the workstations to evaluate participants' procedural skills.

I first gained experience of the ALSO course in the UK where I completed the initial ALSO Providers Course in 1996. I was impressed with the entire approach and philosophy, which focuses on reducing poor outcomes in maternity care through recognition of the complimentary roles of midwives and doctors. I saw the potential of 'ALSO' as a key to breaking down professional barriers and facilitating greater mutual understanding and respect amongst maternity care providers in Australia. Inherent in the ALSO message, was that each of the care providers have important roles and that, usually, in most settings, no one can function entirely alone. In this course, the role of the midwife was seen as significant and important with greater visibility afforded the profession that what I had become accustomed to in my experiences in Australia.

4.4.2 Aim

To describe and analyse a strategy of leadership and collaboration amongst maternity care providers, to make midwifery visible and increase the potential for improved outcomes in maternity care.

4.4.3 Method

Following the completion of the ALSO Providers Course in 1996 a midwifery colleague and I linked with an obstetrician who had become interested in the 'ALSO' program. The three of us returned to the UK in 1998 to complete the 'ALSO' Instructors course. Around this time, some potential funding opportunities had been identified through the endeavours of a retired health risk manager. He too had a vision and a commitment to see 'ALSO' come to Australia. He had made contact with us and, following our return from the UK, we joined together to explore the mechanisms and possibilities for introducing 'ALSO' into Australia. These mechanisms included determining sources of funding, marketing and promotion

strategies, and the development and delivery of the course around the country, including in rural and regional centres.

We formed an informal collaboration and together developed a plan, sought a mechanism for license holding [required by the parent organisation in the USA], and proceeded to inform and raise awareness and interest about ALSO where ever we could (Appendix J). We forged links and networks with obstetricians and midwives who were leading 'ALSO' in the UK, having first introduced it there in 1995.

I worked with my three colleagues from the outset to ensure that the principles of effective collaboration were embedded into how we worked together and how we set up and developed the project. Seeing collaboration as a process rather than an outcome, we sought to make sure that we shared responsibility for decisions made, and communicated clearly on issues of critical importance. From the outset, we recognised our mutual interdependence and need to build collaboration quickly. Of significance was the pre-existing relationship, which I had with the obstetrician in our 'team'. We had worked together effectively some years earlier, and shared a mutual respect for each other's practice and style of working. Importantly to me, he had earlier shown that he valued and understood the role of the midwife, and that he was prepared to share some of his assumed power, as a male, an obstetric leader and an expert clinician. Both my midwife colleague and myself identified this factor early on, as critical to the success in introducing the new program.

Through capable leadership – and our equal participation as collaborators – we established a firm footing and moved forward, modelling the core values of the course from the outset. This was possible because we all recognised the potential advantages of working together on the project and that, because of the multidisciplinary nature of the course, we each needed one another to introduce it. Without this recognition early on, the collaborative project would not have been successful.

We advertised the dates for the courses and hand picked the first cohort of participants. We chose these individuals based on our personal knowledge of their practice base and philosophy of care. Importantly we selected a mix from the three professional groups [midwives, GPs and obstetricians] who would be sure to model and uphold the core values, attitudes and principals of the program. Essentially these core attributes centred on respect for each other's roles and professional boundaries, commitment to evidence based care, and adoption of collaborative practices. Given that all of the work that we would do together was unpaid, we also

sought out individuals who would engage in the 'spirit' of collaboration and working together as an altruistic notion designed to improve outcomes of care.

4.4.4 Results

By January 2001, the first group of 24 ALSO instructors from Australia and New Zealand received their initial course in Canberra. Many of these went on to complete the instructor's course and filled the role of ALSO trainers. Within eighteen months we had conducted twenty provider courses that involved over one thousand GPs, midwives, obstetricians and paediatricians. Within that time frame we also completed three Instructors Courses and trained a total of one hundred instructors. The 'ALSO' initiative has continued to grow and has subsequently developed an Advisory Board responsible for the overseeing and governance of the 'ALSO' course across Australia and New Zealand. There are discussions being held as to how 'ALSO' in this part of the world might be extended to certain Asia Pacific locations in the future.

Anecdotally, the goal of improving inter-disciplinary collaboration, increasing the degree of understanding and respect between midwives and doctors is clearly evident during the two-day course. Feedback from participants includes reports of acquisition of new skills and greater confidence, new insights and perspectives and for some greater appreciation about the role, skills and capacity of others roles and responsibilities. The 'spirit' of multi-disciplinary cooperation that is engendered by 'ALSO' appears to have the capacity to positively influence skills attainment and improve outcomes. My observation through the running of more than twenty-five of these courses is that midwives' confidence levels and self-image appears to be significantly enhanced through their involvement with ALSO.

By 2003, there was a program of twenty courses being offered around Australia and New Zealand annually, each with a capacity to accommodate 48 participants. The course has been officially recognised through becoming accredited by the Australian College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners, for continuing professional development credit points.

4.4.5 Discussion

The leadership processes that we used to engage with each other in the introduction of ALSO were effective. Each of the four members of the group shared the vision for ALSO in Australia and together we were committed to collaborating to ensure its

successful implementation. Each of us was a leader in our field and we each shared a commitment to the ideals and goals of the program.

The key features and attributes of the collaboration, that we embarked upon experientially, are reflected in Section Three, which examines the theoretical frameworks for leadership and collaboration. In essence we developed a structure [the initial group of four, later expanding to become the Advisory Board], which modeled effective inter-professional collaboration. We dealt constructively with difference, using flexible approaches to addressing concerns whilst maintaining the underlying philosophical approach. We developed respect for the various beliefs and viewpoints that existed between us, as practitioners from different professional groups.

Importantly, as leaders, we shared a collective responsibility for the future directions of ALSO in Australia. This is what is referred to in the literature as the shared 'domain' (Gray, 1989). One theorist refers to a process of 'self-regulation' of the domain (Trist, 1977), which is what we as a group were engaged in. The structure enabled the development of new relationships and understandings between stakeholders that lead to increased coordination and communication (Northouse, 1997b). This was essential in the early phase of developing, introducing and later expanding 'ALSO' in Australia.

All of the core philosophical principles, which we started out with, have remained central to the ongoing management, development and sustainability of 'ALSO'. The structure was non-hierarchical in that each member of the initial project team, and later the full advisory board, shared the power and authority for the decisions made. The inaugural Board decided on a dual chair arrangement that saw the obstetrician and myself as the inaugural co-chairs. This contrasted strongly with the hierarchical organisational power structures that many of us experienced in contemporary maternity service provision every day. As such, through 'ALSO', we sought to model a more equitable sharing of power and mutual respect for the differing philosophies and practices of midwives and obstetricians.

The 'ALSO' course is provided across two days on a weekend and participants must commit to attending all sessions as well as the course dinner on the evening of the first day. This is a significant time commitment for participants, on top of the substantial fee required for the course materials and training, as well as travel and accommodation. Instructors, all of who are clinicians from the different professional groups, are also expected to make the full two-day time commitment. They not paid

for their services, receiving expenses only, and they attend because of their commitment to the principles that underpin ALSO.

No formal evaluation of the clinical outcomes of the course has been conducted to date, and the important adverse events that we wish to avoid are rare. However, the outcomes that we seek to improve upon may be beginning to emerge from recent evaluations in the UK with preliminary results showing promise (Henshaw 2003). Observations reported by the National Health Service Litigation Authority in the UK support our experiences here in Australia, which is that, at the very least, confidence levels and subsequent clinical practice do change after ALSO training (National Health Service Litigation Authority 2003) This work also supports earlier reports from the USA that ALSO may be beginning to have a real effect on clinical practice, if not outcomes (Taylor and Kiser 1998).

Our strategy was to promote the message that 'ALSO' had the potential to 'advance the collective good of all of the stakeholders' (Gray, 1989), [namely the improvement of outcomes when dealing with emergencies in maternity care]. Based on my own experiences to date, and numerous discussions with the participants and the faculty of instructors, ALSO's principle of promoting collaboration through multi-disciplinary learning is at the core of their desire to participate. Many of the participants also attend in order to increase their practical competence and confidence. Promoting collaboration in this way offered a decided advantage in that, as a process, it guaranteed that each of the stakeholder groups were heard, involved and recognised for their contribution. In practice, this meant that midwifery autonomy was visible and the professional boundaries of practice of the midwife, were articulated, acknowledged and better understood.

4.4.6 Conclusion

A strategy of leadership to build collaboration amongst maternity care providers is presented, as one example of what is possible when midwives and obstetricians join together to achieve better outcomes.

The 'ALSO' course has been demonstrated to be a positive and challenging way to refresh or learn new skills and develop a standardised, effective and improved approach to managing maternity emergencies. Significantly however, one of its greatest positive benefits in the longer term in Australia may be change in the way health professionals relate to each other. No matter how competent the participants of 'ALSO' courses become, the net benefit experienced by women, as recipients of

maternity care, will not be realised unless this important facet of the course is valued, practised and promoted.

If there is a desire to improve the systems and models of care, it will be imperative that an appropriate level of trust and respect is developed, between the individual providers. This requires clear and visible leadership and modelling, as well as time, initiative and a desire to do so by the majority. Effective communication will be a key, as will the capacity to yield some of the responsibility and power. Clearly, the pursuit of better maternity care for Australian women will be dependent upon the capacity and willingness of individuals to reform their relationships.

The challenges that lie ahead for the leadership of 'ALSO', and those who have received the training, are to make sure that the strong philosophical messages about teamwork, respect and collaboration are carried forward, modelled and widely disseminated.

In the following section I explore the literature and examine the various leadership theories and traits that have emerged from the portfolio of work. Through a review and analysis of the relevant leadership theories from business, marketing and organisational psychology literature, I identify key influences and characteristics of leadership and draw them together to explain the findings reported here.

In an effort to enhance understanding of leadership, as it is applied to the development of maternity services, I also examine collaboration and its potential to improve the outcomes of maternity care and raise the professional capital of midwifery.

5.0 SECTION THREE: PULLING IT ALL TOGETHER - DEVELOPING PROFESSIONAL CAPITAL THROUGH LEADERSHIP

This section presents an essay on the development of professional capital. Drawing on theoretical perspectives from the literature this paper argues that a strategy of focussed and deliberate leadership and collaboration within maternity services in Australia may contribute to the development of professional capital amongst midwives. As a consequence, increased professional capital may enable the profession of midwifery to become more effective, better recognised and more valued. Subsequently, midwives may be able to better contribute to improving outcomes for the women who access maternity services.

5.1 INTRODUCTION

This portfolio examined the lack of recognition of midwifery and its invisibility in maternity care in Australia. The earlier sections provided a rationale and context for the study through a critique of contemporary Australian midwifery, leadership and maternity services development. With a focus on the role of midwifery leadership and its potential to improve collaboration, the portfolio has argued for greater visibility and recognition for midwifery in Australia.

As a midwife committed to improving maternity care and developing the midwifery profession – two goals intrinsically linked, I recognise the need to better understand the nature of inter-professional collaboration and the critical factors that constitute effective leadership. Midwifery leadership and the capacity to work effectively with and alongside others hold enormous potential to improve the systems of maternity care. A greater understanding of enabling factors in health care providers' capacity to work together collaboratively, and the inherent benefits of doing so, may be of benefit to others.

A theoretical explanation of how this occurs and the role that facilitating leadership enables collaboration and the development of professional capital is the focus of this essay.

5.2 BACKGROUND

I have developed the concept of 'professional capital' from an understanding of the literature surrounding 'social capital' (Putnam, 1993; Runyan, Hunter, Socolar, Amaya-Jackson, English, Landsverk, Dubowitz, Browne, Bangdiwala, Mathew, 1998, Kawachi and Berkman, 2000). Social capital is a construct that describes the benefits that emerge from positive social networks and affiliations (Welsh and Pringle, 2001). These effects include the capacity to improve functioning of individuals, networks and relationships that in turn can lead to new and creative ways of supporting and strengthening interpersonal relationships (Achat, Kawachi, Levine, Berkey, Coakley, Colditz, 1998). In examining leadership and collaboration as part of this thesis I have become convinced of the need to strengthen and develop these concepts as key strategies in improving midwifery and maternity care. An additional outcome of this approach may be the positive effect experienced by the midwifery profession itself. It appears that midwifery leadership and collaboration in maternity care are precursors to the creation of an enhanced recognition of midwifery's role, better networking and stronger relationships between midwives and others. This is a construct that I have called 'professional capital'.

I have examined the literature for theories of leadership and collaboration and relate these to current approaches in the organisation and provision of maternity care. I then propose that linkages exist between the development of professional capital for midwives and effective leadership and collaboration. I demonstrate how this is central to addressing the current invisibility of midwifery within mainstream maternity service provision.

5.3 LITERATURE REVIEW

5.3.1 Leadership theories

A leading author on leadership, and advisor to John F Kennedy, James MacGregor Burns referred to leadership as 'one of the most observed and least understood phenomena on earth' (Burns, 1978). Another defines leadership as 'the action of leading or influencing' or 'the ability to lead or influence' (Turner, 1989).

The identification of a single theory that incorporates the full range of prescriptive characteristics, qualities and skills that can be attributed to a leader, is unlikely. More useful, is an understanding of how the various attributes and qualities link, overlap and compliment each other to produce a range of skills and a repertoire that

achieves results. As discussed in the case studies, multiple factors appear to be at work when leadership results in innovation and improvements to services and these become achieved through collaborative endeavours.

5.3.2 Approaches to understanding leadership

Traits, styles and actions

The majority of literature on leadership theory arises from the United States or Britain and can be arranged around several broad themes:

Theories of trait, attitude and personal attributes In the 1930s and 1940s this work promoted a belief that leaders were born, not made and as such only certain individuals had the capacity to become leaders. Effective leaders were most commonly male, or those exhibiting traits stereotyped as masculine (see for example Kouzes and Posners, 1988).

Theories of style and behaviour These imply that certain relationships between individuals, or a particular style and approach of the leader, are what make for effective leadership (see for example Raimond and Eden, 1990).

Theories of 'interactive processes and actions' This work was developed in the 1950's and draws heavily on Maslow's hierarchy of needs theory with the author describing leadership as being about providing direction and inspiration to others, creating teams and generating acceptance from others. These processes take account of three overlapping elements of task, team and individuals so that problems in one element will affect others (see for example Burns, 1978 and Adair, 1998).

Theories of 'skills and ability' This work suggests themes that identify individual abilities such as a high level of self-awareness and personal development with a capacity to create vision, communicate it effectively and with the constancy and perseverance to see it through as being key attributes of leaders (see for example Bennis 1989 and Goleman, 1996).

Leaders and followers

Many theorists (Kouzes and Posners, 1988; Raimond and Eden, 1990; Goleman, 1996; Goleman, Boyatzis, McKee, 2001b) have described leadership in terms of the relationship between leaders and followers, because an individual without followers cannot be referred to as a leader. Indeed it can be argued that it is the followers who

determine whether an individual has leadership qualities. The work of Kouzes and Posners in the late eighties highlights this approach when they considered the effectiveness of leaders and leadership according to the opinions of those being led (Kouzes and Posners, 1988). These authors identified 255 different characteristics of leadership, which they progressively assembled into broad themes. According to Kouzes and Posner the credibility of an effective leader is established through her/his consistency between thought, language and action, so that competencies are centred on the achievement of these outcomes. In order to achieve this, a leader must have vision, creativity, effective communication and the capacity to draw a team of followers together (Kouzes and Posners 1988).

For example, in Case Study One (Section 1) describing clinical practice leadership, it was most commonly the Director or leader who maintained a focus on the outcome we were seeking and it was she who ensured that all stakeholders [followers] remained together and focused. This was played out in various ways. It included the manner in which meetings were chaired and minutes were recorded.

Emotional maturity

According to Raimond and Eden (1990) the emotional competence and capacity of a leader must be such that strategic planning that is encouraged by the leader enhances the free flow of knowledge, ideas, information, values, beliefs and attitudes. These authors suggest that, in seeking this emotional involvement and commitment, essential energy and enthusiasm for change can be harnessed and channelled into the overall effort and shared vision (Raimond and Eden 1990). In my experience of being involved in a number of organisational reviews (Case Study Two), I found this strategy worked in engaging others. Through the use of one to one meetings and interviews, individuals were encouraged to speak of their beliefs, dreams and values as well as the ideas for change within the organisation of care and services. Later I worked with groups of midwives to encourage exchange of ideas and development of consensus and to harness and encourage group energy and support.

Goleman et al (2001) cite research that shows an incontrovertible link between a leader's emotional maturity exemplified by such attributes as self-awareness and empathy, with explicit measures of success in achieving outcomes (Goleman, Boyatzis, McKee, 2001b). Going beyond earlier work linking emotional intelligence with workplace culture (Goleman, 1996), this research indicates that the capacity to create work climates conducive to learning, information sharing, increasing trust and

healthy risk taking between individuals, will be affected by the leader's mood and level of self awareness and emotional intelligence (Goleman, 2000). This in turn drives the moods, actions and outcomes of the entire group, team and / or organisation (Goleman, Boyatzis, McKee, 2001b).

Communicating

Several authors agree that what distinguishes leaders from others is 'vision' and that 'vision' is a central feature which needs 'communicating' to others (Taffinder, 1995b; Northouse, 1997a; Goleman, Boyatzis, McKee, 2001a). Bennis (1989) argues that the critical link between strategic vision and effective leadership is communication. In identifying the link between leadership and language he suggests that it is effective communication skills, which energise, inspire and motivate others. He suggests that the language of leadership can be categorised as two distinct skills: 'framing' and 'rhetorical crafting' (Bennis, 1989). 'Framing' is held to provide a snapshot or action plan of the organisation's mission, vision and sense of direction, presented in a way that is meaningful and which seeks to build confidence and enthusiasm. This is explicated in Case Study Two where we used posters and a newsletter to communicate in an accessible and easily understood manner, the developments that were taking place. 'Rhetorical crafting' according to Bennis (1989), is the use of symbolic language to give an emotional aspect to the framed message. I attempted to use this technique in the regular president reports written for the midwives' association. Using analogies and metaphors, [what I called 'calls to action'], this technique serves to heighten the motivational aspects of the message and is intended to make it memorable (Bennis, 1989). Other authors describe this action as a way of communicating the vision with passion and enthusiasm through vivid language and an expressive style (Goleman, Boyatzis, McKee, 2001b) .

Transactional leadership

Burns conceptualised leadership in terms of a 'leadership-member' exchange model – a two directional process between follower and leader (Burns 1978). This author also distinguished between 'transactional leadership' and 'transformational leadership' (Burns, 1978). Transactional leadership is described as a "process of mutual influence and coalition building; the purpose of which is the exchange of valued services, ideas, resources" (Burns, p87, 1978). This type of leadership is clearly important for midwives who are simultaneously required to form partnerships with women (Guilliland and Pairman, 1995) and to work collaboratively with a range of different health professionals in order to provide appropriate care. The objectives

of the leader and the follower are related, but the relationship does not proceed beyond the exchange or 'transaction' and continues only whilst ever it is required (Burns 1978). This happens quite commonly for midwives working in a community based setting who might engage in a brief collaborative consultation with an obstetrician ('a transaction') and then have no further requirement for a collaborative relationship until the next consultation or 'transaction' is required.

Rosener (1990), in exploring gender differences in leadership style, suggests that this style comes more naturally to men, seeing leadership as transactions with subordinates – exchanging rewards for services rendered and punishing poor performance (Rosener, 1990). Clearly, the leadership style of the obstetrician and the midwife may often be seen as 'transactional'. It is strongly and often negatively gendered in this transactional style (Rosener, 1990).

Transformational leadership

In contrast, 'transformational leadership' sees two or more individuals engaged in interactive processes that bring about increasing motivation and aspiration with an emphasis on progress, achievement and relationship (Rosener 1990). Leaders who possess transformational characteristics are highly appropriate within the current context of service provision that requires effective change management within health care services. Such characteristics include the capacity to be innovative and creative and to bring into existence new structures, systems and processes, with leaders continually raising their own and others' level of motivation and enthusiasm to succeed. This is what Anne-Marie Rafferty (1995) referred to as 'the politics of optimism' whereby leaders influenced change in a concerted way by 'talking up' the issue, putting a positive and palatable angle on the message that followers found appealing and appropriate. Rafferty's study of political leadership in nursing, reported how this approach assisted nursing's visibility in the public sphere through the use of the media as a vehicle to enhance political positioning (Rafferty, 1995). This was the approach used by the Directors in organisation 'A' in Case Study Two of the portfolio, to achieve organisational change.

Transformational leaders are characteristically democratic and participative in decision-making and are people oriented (Burns 1978). Rosener (1990) called this an 'interactive' leadership style that women more often associate themselves with because they work in ways that encourage subordinates to transform their own self interest into the interest of the group, through concern for the broader goal (Rosener 1990). By working to make their interactions with people they lead positive for

everyone involved, women encourage participation, share power and information, enhance other people's self worth and infuse others with excitement about their work (Rosener 1990). Among other things, women value caring, being involved, helping, being responsible, making intuitive decisions and forming networks rather than hierarchies (Kirner and Rayner, 1999). Women are also prepared to negotiate rather than argue, admit mistakes, share the credit and utilise highly effective social and interpersonal skills in building those networks (Rosener 1990; Cox, 1996).

Leadership and organisational culture

It is clear that if a leader is to be effective she / he must also be aware of the culture and values within an organisation and be aware that for some, cohesive values can confront, challenge and produce resistance to change, rather than facilitate change. Culture within an organisation can therefore have an effect upon leadership. Knowledge of the culture and a capacity to positively influence it may be one of the keys to effective leadership. Upon reflection, it is likely that this is the reason that I chose to move on from the medically controlled culture that existed in the tertiary facility within which I worked until 1996 (Case Study One). I believe now that the institutionalised power of the obstetrician in this facility was a significant and insurmountable barrier to truly effective collaboration and therefore any further progress [in expanding midwifery models of care] would not be possible. I relocated to a maternity service that had commenced a process of organisational change and the leaders of the service were committed to creating a culture of evidence based, woman centred maternity care. There was a serious commitment from midwifery and obstetric leaders to explore, analyse and change the prevailing culture [of medical dominance] and move towards a more collaborative approach to service provision (Everitt, Barclay, Chapman, Hurst, Lupi, Wills, 1995). Within this milieu it was my observation that midwifery leadership was so strong that it was what made collaboration with obstetrics possible.

Marshall (1995) suggests that if women are effective leaders in the workplace, then they will not simply change the gender balance but change cultures, institutions and systems as they set about humanising the work environment. Women need to communicate and develop the principles behind this 'female culture' she suggests, and in so doing they may acquire the confidence to do things their way, and in turn, realise change within an organisational culture (Marshall, 1995).

Avolio (1996) describes a 'full range' model of leadership and management development. This involves a vision of new leadership and new management

systems, along a full range of capabilities and systems that is effective at individual, group and organisational cultural level. To be successful, this author argues, transformational change in organisations will require an outright 'attack' on the foundations where we abandon what is no longer working whilst also providing some clear direction to pursue new initiatives. This process of abandonment and identifying future direction requires a higher-level leadership of the type known as transformational leadership (Avolio, 1996).

Leadership as capacity building

A systems-level approach to leadership as described by Avolio (1996) as the 'full range' model, provides a framework for strategic focus on continuous development and capacity building. This work is a useful synthesis of contemporary theories on leadership research and practice and has significant applicability to maternity services development. Avolio's 'full range' model depicts leadership as a 'process' that ranges from the avoidant through the transactional to the inspirational, idealised and transformational styles which can be applied at the individual, group, organisation and community level (Avolio 1996). This author correctly points out that all of the leadership styles or processes can coexist in varying degrees, and play a significant part in individual, group and organisational development. Explicating the 'full range' of leadership is a useful way of discussing where many organisations (or individuals) were, are and would like to be, in terms of developing their human talent (Avolio 1996).

As I reflect on my experiences writing this paper and the empirical and case study work previously presented, I recognise the urgent need to ensure an increase in the number of midwifery leaders both now, and in the future. Avolio's ideas are useful in that he describes how transformational leadership and continuous development are both linked and focussed, as part of a continuum. Specifically, he suggests that the most successful leaders are those individuals who continuously work to build the capacity of people who work with them, so that they may eventually lead themselves. Here the notion of leaders working to build capacity provides a link to my hypothesis of 'professional capital' and the potential to increase functioning of both the individual and the group. He observes that leaders, who have a profound impact on others, typically get them to do more than they expected they were capable of accomplishing (Avolio 1996). Put another way, in my view they enhance their 'professional capital'.

5.3.3 Leadership in Midwifery

All major national, state and local health service reports and recommendations for the development of maternity services cited earlier require midwives to have leadership skills. I have detailed these in the literature within the background section of the portfolio. Leadership is either necessary in order to implement the changes that are needed, or to develop and strengthen the profession so that the changes will be possible in the future. The challenge for the profession of midwifery will be to develop leaders who can develop leadership in others. This will be necessary so that they are able to question the status quo of the current policies and organisation of midwifery and the provision of maternity services to women. By way of addressing a similar challenge, the Royal College of Midwives (RCM) in the United Kingdom (UK) conducted a series of interviews with key opinion formers in the profession. The first published was with Edith Hillan (Barber, 2000; Leathard, 1994) the then Professor of Midwifery at the University of Glasgow, Scotland. Hillan believes that we need visionary leadership to develop quality midwifery services and to inspire and sustain the commitment of midwives during a period of significant change. In my own research of the experience of some of the first Australian team midwives (Brodie, 1996a) I also found that leadership was a strong element in sustaining change. One midwife reported:

“... There was a feeling of being trusted in what we were doing ... we were encouraged to learn our way with the role ... test out our boundaries and limits ... the leaders of the service supported us in trying out different things ... it was how we learnt. There was lot of support from above ... they believed in it more than a lot of midwives ... they could see the benefits”.

(Brodie, 1996a)

There is some evidence that leadership in the form of 'opinion leader education' is more effective in influencing changes to practice than that which might flow from audit feedback or research results (Taffinder, 1995a). With this in mind, it is important to determine what makes an 'opinion leader' in the health professions and what are the attributes of a good leader. Hillan described how, in order for midwives to become leaders, they needed to have a good grasp of the profession and the wider context in which it functioned. She recommended that they needed to have had a varied clinical background and have had opportunities to acquire a broad range of competencies. In calling for universities, employers and professional

organisations to jointly provide continuing education programs for current and future leaders of the profession, Hillan stressed that leaders needed to be identified, supported, developed and encouraged (Barber, 2000).

Some of Hillan's colleagues appear to have taken up this suggestion with the initiation of a conference held in late 2001 in Edinburgh, Scotland entitled 'Championing the way forward for Maternity Services in Scotland: Developing Professional Leaders in Midwifery' (Purton, 2002).

In recognising the link between the lack of identifiable professional leaders in midwifery with concerns about the capacity to reform maternity services, this author has urged consideration of new ways of providing safe and effective maternity services that includes identification of 'professional champions' for midwifery (Purton, 2002).

These actions must also include attention directed at raising the quality of education at both the under graduate and postgraduate level for midwives. It is evident throughout the reflective historical synthesis of my early experiences of leadership in midwifery and maternity services development that my continuing education and professional development assisted me in gaining the skills required to be a leader. Not only did I learn from others. I also became educated and knowledgeable about the different contexts, strategies and characteristics of leadership that I observed and experienced. In considering Hillan's notions of professional champions in midwifery discussed previously, it is clear that such champions will need to emerge from a profession that has acquired significant levels of education and knowledge as well as enhanced professional capital.

5.3.4 Organisational Culture: Medical Control

Clearly, the environment in which midwives practise needs to be one in which they feel safe to challenge, take risks and to learn. If Australian midwifery is at risk of demise, as is suggested in this portfolio then the environment must also support political leadership within the midwifery profession. I concur with Eugene Declercq who suggested that

"Midwives' roles were diminished over the last century not because of their failure as caregivers but because of their failure to respond to the political challenges they faced"

(Declercq, p 237, 1994)

The contemporary organisational culture in which many midwives practise is for the most part characterised by the cultural and gendered authority of medicine in which the obstetrician asserts ultimate power and dominance over decision making. This is evident throughout the case studies in this portfolio and the analysis of midwives' responses to questions about the barriers to midwifery (Brodie, 2002).

Recently there are suggestions that such control and responsibility by one group is problematic and may not be sustainable in maternity care (Maternal and Child Health Consortium, 1998; Australian Medical Workforce Advisory Committee, 1998; Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 1999; Doyal and Cameron, 2000; NHMRC, 1998a).

Having the ultimate authority by implication gives obstetricians full responsibility for outcomes of maternity care. This in turn is a double-edged sword as it increases their likelihood of litigation. It further compounds the challenge of developing collaborative relationships that are necessary for introducing new models of care that increase midwives' visibility and contribution. In my experience, many obstetricians have applauded the concept [of midwifery autonomy] and have appreciated the scientific basis of its benefits, but they have been unwilling to engage or collaborate claiming medico-legal problems if they consort with lesser-trained and poorly indemnified midwives. This is reinforced by the current funding system of maternity care in Australia that prioritises medical care for pregnancy and birth, with structures that maximises economic benefit to the medical profession, in part through maintenance of the subordination of midwives (Willis, 1983).

This organisational culture serves to sustain obstetrics and at the same time contributes to the decline of midwifery professionalism in Australia. The invisibility of the midwife has been shown in this portfolio to be reinforced by public perceptions that value technology and 'being in control', and government policy that prioritises medical responsibility for childbirth. Arney's work on power and the profession of obstetrics offers important insights here in suggesting that obstetrician's growing concerns with, and desire for, control of the normal, may account for the apparent increasing emphasis on teamwork (Arney, 1982). With this in mind, most midwives have no choice but to pursue strong alliances with women and create opportunities to collaborate with doctors if they wish to not only remain in practice, but also to contribute to effecting change from within.

The practice domain of midwives is that of normal pregnancy and birth and this has been, and arguably remains under threat of medical dominance (Treffers and Pel,

1995; Downe, McCormick, Beech, 2001). The expanding input of medical personnel and medical policy into uncomplicated childbearing and midwifery practice is well recognised and thoroughly exemplified in the case of the 'episiotomy', which has been 'normalised' as a 'necessary' intervention (Graham, 1997). Increasingly in Australia, where a significant percentage of women have private health insurance, obstetricians are attending normal births (AIHW, 1998; AIHW, 2001). The negative consequences of this shift to more medical care are demonstrated through evidence of poorer outcomes (Roberts, Tracy, Peat, 1999) (Johanson, Newburn, Macfarlane, 2002). Additionally, within this organisational milieu obstetricians assert the right to define what constitutes 'normal' and to determine the scope of maternity care and practice (Australian Council on Health Standards, 1997). Compounding these issues are the current costs of medical indemnity, which are creating a crisis in Australia. The future organisational and policy context for maternity care might shift depending on the government response to these private health insurance issues that are currently receiving close scrutiny. Again the complete lack of visibility and involvement of midwives and consumers in the decision-making processes suggests that major changes are not likely.

5.3.5 Theories on collaboration

The simplest definition of collaboration can be found in the Oxford dictionary (Turner, 1989) which describes the meaning of the term collaboration as to 'work jointly on a project, especially a literary, artistic or scientific project', or 'to cooperate traitorously with an enemy'. Further, from the root words ['coll.'] 'college' means 'an organised body of persons with shared functions and privileges', whilst 'labour' means to 'exert one self or work hard' (Turner, 1989). For the purposes of this thesis, collaboration in maternity care is understood by the writer to mean:

'... the exercising of effort by midwives and doctors towards each other for the purposes of shared functions, namely the provision of safe, rewarding and effective care to women and their families'.

This meaning is adopted for the purposes of explaining the writer's perspective on collaboration. Later it will be acknowledged that in practice, quite often the term is confused with 'cooperation', which may or may not be experienced 'traitorously' between enemies.

Theorist Michael Schrage conceives of collaboration as being like 'romance' and like romance, it is difficult to define (Schrage, 1990). According to Schrage, romance

embraces a continuum of interaction from the simple flirtation to a deep and abiding love, as well as every single possible permutation in between. The collaborative continuum is similar in that it

"... stretches over vast possibilities of interaction: from the serendipitous stranger saying the right thing at the right time to the decades long mutual obsession of two scientists to tap out the secrets of molecular biology."

(Schrage, 1990 p46).

Schrage suggest that collaborations have their own brand of simple 'flirtations' through to deep and abiding commitments. Passivity is not a feature of collaboration. Like a romantic couple, collaborators are constantly reacting and responding to each other. Frequency of contact becomes almost as important as the nature of the contact. The collaboration becomes an entity unto itself (Schrage, 1990).

The critical difference, in Schrage's view, is that, unlike romance, collaboration is supposed to produce something. Collaboration is a purposive relationship. At the very heart of collaboration is a desire or need to either solve a problem or create something, usually within a set of constraints. These constraints include

- Expertise - one person alone does not know enough to deal with the situation
- Time - collaboration requires a real-time commitment
- Money - may be required to support an initiative or people's time
- Competition - others may threaten to beat a collaborative team to the decision or market
- Conventional wisdom - the prejudices of the day will constrain or enhance the process

(Schrage, 1990)

Given these constraints, collaboration cannot be routine or necessarily predictable. People collaborate precisely because they don't know - or cannot - deal effectively with the challenges that face them as individuals. There is uncertainty because they genuinely don't know how they will get from 'here' to 'there' and they require others to work with them in an inter-dependent way to achieve results. In contemporary maternity care this gets played out in a myriad of ways according to existing

relationships of trust or otherwise, the agreed protocols and practices and the particular demands of the clinical situation.

This 'interdependence' is one of five key features of collaboration that are critical to the process, according to behavioural scientist Barbara Gray. In the initial phase of any collaboration it is important that each of the parties become aware of how each of their concerns are intertwined and the reasons why they need each other to reach an outcome (Gray, 1989). Parties in conflict can easily lose sight of this and reminding each other of this critical ingredient often kindles renewed willingness to search for the particular trade offs that could produce a mutually beneficial outcome. Within hospital based maternity care settings it is often stated that 'midwives and doctors cannot survive without each other'. Gray suggests however that clear understanding of exactly what each other's concerns are and 'why' each group needs each other is more often assumed rather than explicated or agreed upon.

Other dynamics of collaboration described by Gray (1989) and others that are useful in the arguments built in this essay are summarised below:

- Solutions emerge by dealing constructively with difference. There are multiple approaches to multiple concerns; without differing interests the range of possible exchanges between the parties would be non-existent; learning to harness the potential is a key. Testing each other's assumptions may reveal that the underlying concerns are the same; these beliefs and viewpoints are consistent with their independent efforts to confront the problem
- Joint ownership of decisions. Everyone is directly responsible for reaching agreement on a solution; the parties impose decisions on themselves. Three steps in reaching this joint decision include (1) the joint search for information about the problem (2) the invention of a mutually agreed upon solution about the pattern of future exchanges between stakeholders, and (3) ratification of the plans for implementing it.
- Collective responsibility for future direction of the 'domain'. Trist refers to this as 'self-regulation' of the domain (Trist, 1977), which involves the development of new relationships, and understandings between stakeholders that may lead to increased coordination and communication in the future.
- Collaboration is an emergent process rather than an outcome; a 'temporary and evolving forum for addressing a problem' (Gray, 1989). By viewing it in this way, it becomes possible to describe its origins and development over time. Thus,

collaborations move from 'under organised systems' in which all stakeholders act independently, to more tightly organised relationships characterised by concerted decision making.

Abstracted from (Gray, 1989).

Gray's work portrays the dynamic and forever changing domain of collaboration that is a part of the everyday relationships and organisational culture of maternity care. Thus, envisioning collaboration as a process rather than an outcome in which stakeholders assume responsibility for decisions made enables investigation of how innovation and change in currently unsatisfactory relationships can occur. If collaboration is successful, new solutions emerge that no single party could have envisaged or enacted (Gray, 1999). Applied to maternity service provision and effective care, such a process requires deliberate focus, articulation, understanding and the leadership of professionals. While ever collaboration as part of routine care is not made explicit, it's powerful potential for improved decision making and better outcomes cannot be realised. More over it may work to hide what may simply be 'cooperation' by midwives who are in a subservient and subordinate position within the inter-professional relationship.

5.3.6 Collaboration within organisations

In reviewing the research on inter-organisational collaboration Cynthia Hardy and others explored the complex role that collective identity has on an organisation's capacity to generate collaborative relationships (Hardy, Lawrence, Phillips, 1999). In building further upon Gray's work (cited above) regarding the potential benefits of collaboration, these authors refer to problems with collaboration related to a blurring of boundaries and professional identities. They suggest that collaboration embodies a particular struggle for individuals related to maintaining their own identity whilst engaging in a dynamic process that aims to create a new identity – the collaboration itself, or what Trist refers to as the 'domain' (Trist, 1977). If participants do not engage with the collaboration they are likely to limit its potential, but in so doing they may also engender differences and conflicts that contradict with or challenge their own individual roles and professional boundaries. These authors recommend exploration of the competing and conflicting interests as well as the articulation of the separate identities that exist, before pursuing the construction of a collective identity that is integral to successful collaboration (Hardy, Lawrence, Phillips, 1999).

5.3.7 Collaboration across professional boundaries

The role of the midwife is different to that of the obstetrician and this is not always clearly understood (Deery and Kirkham, 2000; Stafford, 2001). In practice, within contemporary maternity services, midwifery autonomy is not acknowledged or supported and very often the scope and boundaries of midwifery practice are blurred and confused (Robinson, 1989; Watson, Potter, Donaghue, 1999) (Kirkham and Stapleton, 1999a; Kirkham, 2000) (Ball, Curtis, Kirkham, 2002). Models of midwifery care that support autonomy and recognise the professional boundaries of practice of the midwife are still rare in Australia (Homer, Brodie, Leap, 2001).

The inter-occupational boundaries that exist between midwifery and medical practice have been explored in depth by sociologist Anne Witz (Witz, 1992). In this decisive work Witz examines the way in which the male power [of obstetricians] has been used to limit the employment aspirations of women [as midwives] since the seventeenth century. In examining the subject of professions and power, this author brings together feminist and sociological concepts to explore the sources of professional power and demonstrates how class and gender have interacted to produce hierarchies of power and prestige within the health care professions (Witz, 1992). Witz develops the idea of conceptual 'tools of closure' or demarcation that help to elucidate the dimensions of closure in professionalising occupations such as midwifery. The tools or strategies of closure adopted by midwives are cited as "dual", in that they were both "revolutionary" and "accommodative" (Witz, 1992) p 105. These were developed in response to medical men's strategies to achieve demarcation and gendered control of childbirth practices and care (Witz, 1992).

The 'revolutionary' strategy had the purpose of redefining relations between medical men and midwives with midwives re-skilling and becoming established along side medical men, in a similar way to that of dentists. Thus midwives would become demarcated through a process of occupational incorporation and dissolution of the separate occupational role and identity. The 'accommodative' strategy would have midwives conceding to a more limited and restricted role, in which they become clearly subordinate to medical men in the medical division of labour (Witz, 1992). According to Witz, the critical difference between the two was that the de-skilling strategy sought to preserve the role of the midwife as an independent practitioner, whilst the incorporation strategy sought to reduce the role to that of obstetric nurse and 'handmaiden' (Donnison, 1977) to the medical man (Ehrenreich and English D, 1973). And REGO.

The focus of the struggle became constructed and played out as a division between assistance and intervention in the very process of labour itself, with divisions into 'normal' and 'abnormal' conditions (Witz, 1992). Through the 'accommodative' strategy, the sphere of competence of midwives, as prescribed by the medical profession became restricted to the attendance at normal labour, which became enshrined with the passage of the 1902 Midwives Act (Leap and Hunter, 1993).

In analysing the professionalisation of trained midwives, which occurred in the 19th century in Britain, Witz conceptualises the idea of the 'female professional project' as a strategy used by midwives to achieve occupational closure and thus monopoly over the provision of certain skills and competencies (Witz, 1992). This involved the use of exclusionary tactics such as credentialing and legalisation, designed to secure a link between education and occupation, as well as to usurp the actions of medical men who sought to impose their own de-skilling and demarcation strategies. The boundaries between midwifery practice and medical practice were also gendered in that 'surgical' skills were the domain of medical men and 'caring' became the domain of the female midwives (Witz, 1992).

The resulting demarcation lines of practice, that were established in the 19th century, based on sexually segregated spheres of competence in the medical division of labour, continue to influence the nature and organisation of contemporary maternity service provision (Carpenter, 1993; Pringle, 1998b). In the 19th century, midwives and doctors were positioned in patriarchal structures that reinforced male power to the point that it became institutionalised, not just around the sphere of practice, but also within society and the state. Witz's analysis gives important insight and understanding of some of the barriers to effective collaboration that exist in maternity services provision. To this day, and to varying degrees, these patriarchal structures remain and continue to impact and constrain the professional role and scope of practice of midwives. Clearly, it is essential that they be considered in any attempt to improve inter-professional relationships or to challenge the existing systems of maternity care.

Notwithstanding the hierarchical power and gender based issues that continue to influence midwives' practice domain, clashes of philosophy and differences in the practices of midwives and obstetricians are often cited as reasons for collaboration not being achievable. Again the work of social scientists Hardy and her colleagues (Hardy, Lawrence, Phillips, 1999) contribute further understanding to the issue of collaboration. They suggest that without the construction of a collective identity

where the goals of individuals and the organisation are shared, collaborative relationships cannot develop and organisational objectives cannot be achieved. Furthermore, without a collective identity, strategic action (for example organisational change to embrace new models of care in maternity services) will not be generated (Hardy, Lawrence, Phillips, 1999). Significantly, however, these authors assert that collective identities are also socially constructed, interwoven from the many discourses that are variously coherent or fragmented, stable or dynamic, single or multiple according to the various negotiations of the individuals and groups involved (Hardy, Lawrence, Phillips, 1999). This work is highly relevant to the dynamic and often unstable organisational relationships that are a feature of maternity care. Many hospitals, especially those with a large number of births and therefore large workforce numbers, experience frequent changes in the membership of midwives and doctors that constitute what is referred to as the 'team'. In applying this discussion to an understanding of effective collaboration in maternity care, it is clear that significant work and leadership is required at the inter-professional level, between the colleges of obstetricians and midwives, as well as at a local practice basis if any change is to occur.

In her work on the development of inter-professional work in Britain, Audrey Leathard highlights a 'terminological quagmire'. This author cites what she calls "an ever expanding range of professionals, carers and cared for as well as a variety of organisations and sectors all having a part to play in health and welfare" (Leathard, 1994 p5). This is true of the current systems of maternity care with the range of service providers encompassing specialist obstetricians, GPs, midwives, student doctors and midwives, lactation consultants, childbirth educators, enrolled nurses and maternity aides, maternal and child health workers and more recently the 'doula' (Mander, 2001). Whilst cautioning against the grouping of terms, Leathard suggests that redefining and clarifying terminology is essential to furthering the debate on how individuals work and learn together. In an attempt to clarify understanding, a table is provided which sets out one method of classifying the various complexities of terms that denote the concepts of working and learning together. These terms are drawn from the work of both Leathard (1994) and Duerst-Lahti and Kelly (1995), to reflect the range of alternative terms commonly used in health care by health professionals.

Table 1: Inter-professional working - concepts and terminology*

Concept-based	Process-based	Agency-based
Inter-disciplinary	Collaboration	Inter-agency
Multi-disciplinary	Partnership	Inter-sectoral
Multi-professional	Teamwork	Trans-sectoral
Trans-professional	Cooperation	Consortium
Trans-disciplinary	Participation	Healthy alliances
Holistic	Shared learning	Forum
Generic	Liaison	Federation
	Integration	Locality groups

*Adapted from Leathard, 1994 and Duerst-Lahti and Kelly, 1995

What is critical, according to Leathard, is that terms has different connotations and as such consideration must be given to ensuring that all stakeholders share a common understanding and express a desire to find a way to work together to achieve a mutually agreed outcome. Many of the terms are used to indicate that the focus of operations overlap easily. In maternity care it is assumed that the focus of collaboration is the woman herself being the recipient of care (known as 'woman-centred care'), however other beneficiaries may be the agencies, institutions and care providers themselves who stand to gain or lose considerably from effective processes of collaboration. Obstetricians in private practice could lose from a true collaborative venture with midwives. As such it is likely that it is within the public health services that effective collaboration may be realised in the future.

5.3.8 Purpose and effect of collaboration

In his critique of teamwork, Schrage (1990) points out that collaboration is a far richer process with the issue being not simply one of communication or teamwork, but rather the 'creation of value'. He describes a necessary process of value creation that the traditional structures of teamwork and communication cannot achieve. Schrage defines collaboration as:

"a process of shared creation: two or more individuals with complimentary skills interacting to create shared understanding that none had previously possessed or could have come to on their own"

(Schrage, p40,1990)

Collaboration creates a shared meaning about a process, a product or an event, which in this portfolio I identify as the desire for 'best' outcomes of maternity care for women. As such, the true medium of collaboration is other people, with real innovation coming from the social matrix. The actual process of collaboration is hard to measure with its many levels of conversations, interactions and communications. Collaboration, Schrage suggests, is not described in terms of the relationships it may create but in terms of the objective to be achieved. In support of this, Schofield suggests that the main reason for collaboration is to improve the quality of professional decision making, which in turn has the potential to make care more cost effective with less duplication (Schofield, 1992). This reflects the work of Bourdieu who suggests that:

"Interprofessional collaboration challenges professionals to rethink their purpose and to discover the most effective means of practice"

(Bourdieu, p 27, 1987)

By focusing on interests and encouraging the exploration of differences, the potential to discover novel, innovative solutions or strategies is enhanced. Even when parties are unable to reach agreement or closure through collaboration some benefits from collaborating are still possible, according to Schofield (Schofield, 1992). The process of collaborating usually leaves parties with a clearer understanding of their differences and an improved working relationship. Such potential to build capacity and productivity through improved inter-professional relations suggest another link to 'professional capital'. The capital or 'value creation' referred to by Schrage (1990) augers well for future experiences of working together despite an appearance of not reaching agreement. He suggests that

"it is the change in the nature of the interactions that has the greatest impact upon behaviour", and that collaboration is "the greatest source of increased productivity and new value in an enterprise"

(Schrage, p42, 1990)

Hardy and colleagues, in examining various organisational theories of collaboration, conclude that the basis of effective collaboration is collective identity and that the foundation of collective identity is conversation (Hardy, Lawrence, Phillips, 1999). These authors suggest that collaboration and the beneficial changes that it brings about are bound up with a struggle between competing conversations, identities and influences, and that the key is to manage and sustain that struggle, through the maintenance of a connected identity (Hardy, Lawrence, Phillips, 1999). In doing so, these authors argue, collaboration that recognises the individual identities and positions, as well as the collective identity, will more likely enable new solutions, practices or better outcomes to emerge that any single party could have envisaged or enacted (Gray, 1999). Again, such a situation is only going to be possible within the public health system, when major threats to a 'collective identity', such as financial incentives for one group, are removed.

Applied to maternity care, women as recipients of care stand to benefit greatly if the carers are able to reflect on their processes of communication and examine how shared or unilateral decision-making affects outcomes. This is most obvious in the care of women who are experiencing complications of pregnancy or who have known risk factors. Effective communication, focusing on the individual needs of the woman, recognising the complimentary but unique roles and boundaries of practice that exist between health professionals, is at the centre of risk management, harm reduction and improving birthing experiences for women (Maternal and Child Health Consortium, 1998). This is a critical interpretation of collaborative relationships in maternity care. The challenge of maintaining one's individual role and identity, whilst engaging in a process of creating a productive and effective collective identity, will be a challenging experience for midwives. This will require knowledge, skills, confidence, self esteem and support from leaders.

As previously stated, the main purpose of collaboration is the shared creation of new understandings that are not achievable by the individuals alone (Trist, 1977; Kramer and Tyler, 1996). This is not merely the sum total of each individual contribution or effort, but rather the 'product' that emerges from the process of collective interactions that occur throughout the collaborative venture. In this paper, I propose that this 'product' can be identified and named 'professional capital', the understanding of which carries with it potential for enhancing the essential role and effectiveness of midwives.

Clearly, consideration of the many conditions and factors that contribute to an effective collaboration is critical to understanding its capacity and potential. Several authors have suggested a number of environmental, practical, procedural and interpersonal factors within collaborative endeavours, that are necessary for true collaboration to occur. These are important when considering the effect that collaboration between the professions might have in the improvement of maternity services. The development and unfolding of this initiative will require a large amount of time, effort, planning, preparation and consultation by and with all the key stakeholders in maternity service provision. Attention to detail, including that of effective 'processes' will be critical to achieving value and the desired positive outcomes. This may become useful in achieving what Gray describes as a 'multi-party strategic alliance' (Gray, 1989), for developing not only effective maternity services but also an effective and visible profession of midwifery for the future.

The actual area of interest for the collaboration or 'the inter-organisational problem domain' (Trist, 1977) needs further elaboration. From Trist's (1977) work the 'problem domain' is defined as "the way a problem is conceptualised" (p12), Understanding this is important to setting up the collaborative process around the problem domain and to developing collaborative responses to it. The development of a model of continuity of care for women with risk-associated pregnancies, which occurred in 1997 at St George Hospital in Sydney, provides an excellent example of this process in action (Farrell, 2002; Homer, 2002). In this case, all stakeholders (for example physicians, midwives, obstetricians, paediatricians and others) were able to recognise the various needs that this client group had, and also articulate their own individual concerns and expectations. Thus, the conceptualising of the domain and the collaborative processes required to address, it could then be clearly identified and expressed.

5.3.9 Collaboration and inter-dependence

Recognition of mutual interdependence by the stakeholders is important early in the attempts to build collaboration. It is this process of valuing midwifery's contribution and leadership – exemplified through their equal participation as collaborators - that appears to build professional capital. This may be initiated because each person recognises the potential advantages of working together on the problem or because they need each other in order to solve it. Without this recognition the collaboration will not proceed.

The potential to advance the 'collective good' of all of the stakeholders through the pooling of resources or, alternatively, the cost of doing nothing being too high, also requires recognition. Collaborative initiatives offer a decided advantage over other methods of decision making in that they guarantee that everybody gets heard. If collaboration is successful new solutions emerge that no single party could have envisioned or enacted (Gray, 1989).

Seeing collaboration as an emergent and ongoing process rather than an outcome, in which stakeholders assume responsibility, assists in gaining understanding of how innovation and change might occur. Once initiated, collaboration creates a forum within which consensus about the problem can be sought, mutually agreeable solutions can be invented, and collective actions to implement the solutions can be taken. Viewing collaboration as a process also enables description of its origins and development as well as knowledge of how it may change over time. For these reasons, attention to the process of setting up and supporting the collaboration becomes critical to its success. Similarly, understanding the process offers enhanced capacity for the work and experiences gained to be shared for the benefit of others who are seeking to do similar. This will require confidence and a capacity to contribute as well as strong professional networks and relationships. Arguably, it may only be possible when midwives possess professional capital.

5.3.10 Why collaborate in maternity care?

As has been identified previously, the concept and experience of collaboration holds different connotations for each person. Many midwives and doctors would report that they collaborate as a matter of course in their day-to-day practice. Whether they are collaborating, consulting, referring or simply cooperating is rarely explored. As such, the potential benefits that might ensue from more positive and effective relationships cannot be fully realised. It is self evident that, through collaboration, teamwork and sharing of clinical information and skills, midwives and doctors have a greater chance to improve the outcomes for women and babies. This is especially true when birth presents unexpected and life threatening emergencies. It is here that the underlying message and skills development of the 'Advanced Life Support in Obstetrics' course (ALSO)⁵ can demonstrate its potential. The 'Advanced Life Support in Obstetrics' course (ALSO) states that its key objectives are to:

⁵ The introduction of the 'ALSO' course as a strategy to improve collaboration between midwives and doctors across Australia was explored in Section Two of this portfolio

- Discuss ways of improving the management of obstetrical urgencies and emergencies which may help standardise the skills of practising maternity care providers
- Discuss the importance of utilising regional maternity care services and identify possible barriers which might limit access
- Successfully complete the course written test and mega-delivery station

These objectives are met through the promotion of inter-disciplinary teaching and learning with the course being geared for all maternity care providers (American Academy of Family Physicians, 2000). This includes midwives, obstetricians, GPs, nurses, paramedics, health workers and trainees. One of the greatest strengths of ALSO is that it is only ever run as a multi-disciplinary course, since cross professional networking and socialising are seen as crucial. The messages promote and model collaboration, good communication and inter-professional trust, which are associated with improved outcomes for women and their babies (Department of Health UK, 1998). As discussed in Section Two, the ability to learn on an equal footing through an overtly collaborative structure that focuses on breaking down hierarchical barriers is described as an eye-opening experience for all concerned. This approach of ALSO overtly seeks to break down barriers that have been identified as contributing to poor outcomes (Boon and Holmes, 1991; Doyal and Cameron, 2000; Barbour, 2001).

Collaboration in maternity care presents many opportunities in addition to those related to improving care for women experiencing crises and emergencies. The successful implementation of new models of care, that place the woman at the centre of care and increase the autonomy of midwives, may well be dependent upon inter-professional trust and collaboration (Brodie, 1996a). In settings where new models of care and effective collaborative relationships between midwives and obstetricians are developed simultaneously, a number of potentially beneficial effects have been suggested. These include:

- Increased continuity of care and carer - care 'follows the woman' regardless of the development of risk factors (McCourt, Page, Hewison, 1998)
- Maintenance of midwifery as a central component in the care of all women (Hodnett, 2004a)
- Development of autonomous midwifery skills and confidence (Page, 2000)

- Maintenance of the integrity of the role and range of skills of the midwife - not 'sub specialising' (Page, 1999)
- Improved relationships and experiences – for women, midwives, doctors (Brodie, 1996a; Homer, Davis, Brodie, et al, 2001)
- The potential to improve clinical outcomes (Homer, Davis, Brodie, et al, 2001)

Despite the potential benefits of enhanced collaboration there is little evidence of models of care designed to increase collaboration as an 'intervention' aimed at improving experiences for both women and the health professionals. In the UK the 'Confidential Enquiry into Stillbirths and Deaths in Infancy (CEISDI) Report', recommended greater collaboration, communication and consensus decision making as central to reducing negative outcomes in care (Maternal and Child Health Consortium, 1998).

The model that we developed in Australia, the 'St George Outreach Maternity Program (STOMP)' was set up with a deliberate focus on collaboration between midwives and obstetricians as part of a community based maternity service available to women of all levels of risk. Outcomes of the randomised controlled trial at St George involving 1089 women demonstrated a significant difference in the caesarean section rate between the groups, 13.3% in the STOMP group and 17.8% in the control group. This difference was maintained after controlling for known contributing factors to caesarean. Women receiving STOMP care were more satisfied and costs associated with the new model were less than for standard care (Homer, Davis, Brodie, 2000; Homer, Matha, Jordan, Wills, Davis, 2001; Homer, Davis, Brodie, et al, 2001). Despite the significant benefits of this relatively new form of care there is as yet little evidence of its widespread introduction in Australia. As one of the midwives involved in the development and implementation of the STOMP model I am able to speak directly of my experiences of its benefits and also to critique why it has not been readily adopted by other organisations.

It is my view, from over twenty years of practice that, traditionally, midwives have had relationships with doctors that were enabling for the doctors. It is now time to develop relationships that are enabling for midwives. When midwives and doctors collaborate effectively there are exchanges of essential ideas and information. This exchange of ideas and information can only occur if there is a sharing of power and responsibility along with recognition of the need for occupational autonomy. In contemporary maternity services, provision of such 'sharing' of power' in essence means that doctors must give up some of their power. Crucially, understanding of

the need for, recognition of, and respect for the existence of, the unique and separate identities (Hardy, Lawrence, Phillips, 1999) of midwife and obstetrician, will be integral to the success of any collaboration in maternity care. Such understanding will be crucial as collaborative processes begin to develop and the inevitable exploration of competing and conflicting interests and power differentials unfold.

Within contemporary maternity care and service provision, the necessary sharing of power that enables collaborative decision-making, is not common. As has been demonstrated by research with midwives in Australia in Part Two of this portfolio, the role of the midwife continues to be viewed as being dominated by medicine (Willis, 1983) and controlled by nursing (Barclay, 1985; Summers, 1998b). This is further exacerbated in the clinical setting by the perception that the medical profession controls and influences management decisions and resources. In maternity care, this 'occupational imperialism' (Larkin, 1983) subordinates midwifery by ensuring strategic control of clinical care and decision making and limiting the occupational autonomy of midwives. Publicly, this is reinforced by government policy that prioritises and funds medical responsibility for maternity care.

Exactly how midwives can address this significant barrier is an important question. The answers lie in a complex range of challenges and strategies that midwives individually and collectively must address urgently. If collaborative relationships and more effective team working is to be realised, well informed and skilful leadership at a local and global level, will be required that draws on evidence and international experience to bring about changes in the organisation of contemporary maternity services. Midwives relate this to opportunities for learning and demonstration of knowledge through leadership. Integral to this will be the necessary development of trust and mutual respect, generated by the individual and separate identities of care providers who have the capacity to share power and to some extent blur the boundaries of practice and decision-making. All of these attributes contribute to what Trist refers to as an inter-professional domain of trust which is a key to effective inter-professional collaboration (Trist, 1977).

5.3.11 The importance of trust

In any human relationship, the defining element is trust between individuals and a reciprocity that assumes that trust will be both given and expected. Trust is a critical success element to most business, professional and employment relationships as well as its more obvious component in satisfying personal and romantic

connections. It is therefore essential to examine the concept of trust as it applies to the development and maintenance of collaborative relationships in contemporary maternity care.

The past decade has seen significant change in the management of hospitals and health services. As such, inter-professional working relationships are expected, and in some cases are being forced, to change (Leeder, 1999; Doyal and Cameron, 2000; Allen, 2000). Furthermore, the changing face of the maternity workforce (Tucker, Hall, Howie, Reid, Barbour, du V Florey, McIlwaine, 1996; Australian Medical Workforce Advisory Committee, 1998; Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 1999; Salvage and Smith, 2000; Kirkham and Stapleton, 2000; Barbour, 2001) presents imperatives, for those that provide the care, to adjust and adapt to new expectations, conditions and influences.

One of these imperatives is the need to move away from traditional hierarchical forms of managing organisations towards the formation of networks and alliances of individuals who share similar goals or client groups (Zwarenstein and Reeves, 2000). These new alliances are designed to be more responsive and adaptive to change and more effective in their approaches. This enables innovation and creativity to develop and effectiveness of communication and problem solving to increase (Ford and Iliffe, 1996; Davies, 2000; Doyal and Cameron, 2000; Goleman, Boyatzis, McKee, 2001b).

The development and maintenance of collaborative partnerships between maternity care providers is a critical factor in the successful implementation of new models of care that improve experiences and outcomes for women (Homer, Davis, Brodie, et al, 2001). In my experience of implementing this model of care that was evaluated by Homer et al (2001), the development of trust between midwives and obstetricians was a crucial element in both the development and subsequent sustainability of the model. Midwives were required to work alone or in pairs as autonomous practitioners based in a community setting, separate from the mainstream hospital services and personnel. They made clinical decisions under their own responsibility and scope of practice, and referred and consulted with obstetricians and others as necessary. Whilst the nature of the study made it impossible to measure a cause and effect, I assert that the collaboration itself was a critical factor in the impressive outcomes for the women experiencing this care [4% reduction in caesarean section rate; women more satisfied and costs were less] (Homer, Davis, Brodie, 2000;

Homer, Matha, Jordan, Wills, Davis, 2001; Homer, Davis, Brodie, et al, 2001). This collaborative professional relationship was based on a clear understanding of roles and boundaries of practice and a growing level of respect and trust that developed between midwives and obstetricians and continues to the present day (Homer, Brodie, Leap, 2001).

Arguably the STOMP model would not have been implemented or sustained without informed and knowledgeable midwifery leadership and effective inter-disciplinary collaboration. This occurred throughout the initial planning, development and subsequent implementation, as discussed in Section One, Case Study Two. Sound leadership across professional disciplines and effective pre-planning and management of organisational change had created the 'right' organisational context for practice for innovation and change to be introduced. The higher level of knowledge and leadership of the midwives involved destabilised the conventional power base. The lead researcher was completing her PhD. I brought practice experience as well as knowledge from my Masters thesis. A Professor of Midwifery supported us and together we joined with other midwifery clinicians and managers to collaborate with the obstetricians involved. Supported by Commonwealth government research funds to complete the randomised controlled trial of the new model (Homer, Davis, Brodie, et al, 2001), all of these factors coalesced to enable the collaboration to unfold.

5.3.12 Theories on trust

There is a growing body of literature that assists in explaining why and how trust is an essential element of collaborative relationships and organisational effectiveness. Much of this is useful in gaining understanding of collaboration and leadership in midwifery and maternity care. Limerick and Cunningham's (1993) work effectively highlights changes in the contemporary organisation and the increased emphasis on interpersonal skills and communication, particularly trust, in the workplace (Limerick and Cunningham, 1993). Much social science literature has given attention to the concept of trust including psychology, sociology, political science, history and economics, each with its individual and different lens and approach. Various perspectives have emerged that propose different explanations and theories. There is very little literature however that attempts to integrate these different perspectives, or articulate the role that different perspectives might play in critical social processes involving human interactions and relationships; for example cooperation, coordination or collaboration in the provision of health care.

The social – psychological perspective emphasises the nature of trust in interpersonal transactions and this has relevance and applicability to this examination of how trust develops in collaborative relationships. Application of how trust develops in the context of romantic relationships as described by Boon and Holmes (1991) also allows extrapolation to inter-professional working relationships. This links appropriately with my earlier use of Schrage's work when describing collaboration as like romance that "embraces a continuum of interaction from the simple flirtation to a deep and abiding love, as well as every single possible permutation in between" (Schrage, 1990) p46.

Trust in collaborative relationships has been cited as also being similar to romance in that it moves through three stages: the romantic love stage, the evaluative stage and the accommodative stage (Boon and Holmes, 1991). According to these authors in the romantic love stage, the parties experience a surge of positive feelings towards each other and at this stage love and trust are indistinguishable. As sustained contact continues, each of the parties will reveal imperfections and weaknesses that will require the other to step back and evaluate the relationship more broadly. During this phase, as the 'pros and cons' of the relationship are debated and the players learn to trust each other, these authors assert that this is when 'real' trust takes root. Finally in the accommodative stage, negotiations of conflicting needs and expectations take place and the parties solidify the necessary trust to sustain the relationship (Boon and Holmes, 1991). What is most useful in this description of romantic relationship building is the element of evolution, with the dynamics of building trust being different at each stage of its developmental processes. Trust takes on different characteristics according to what stage of its maturity has been reached. Clearly this is highly relevant to the gaining of an understanding of trust in the workplace generally and in maternity care in particular. My experiences and observations of relationships that evolved over time in the STOMP model were very similar to those described by the theorists cited here. Importantly, the dynamic and forever changing membership of health care teams and organisations presents a particular challenge to the creation and sustainability of trust in the long term. I reflect on this issue in the epilogue of the portfolio.

In professional business relationships trust has been described as having three forms:

- Deterrence-based trust, which is based on consistency of behaviour with consequences for not maintaining an action

- Knowledge-based trust, which is grounded in behavioural predictability and judgement of probable behaviour of others
- Identification-based trust, which is based on complete empathy with the others desires and intentions

(Kramer and Tyler, 1996)

These descriptions are readily extrapolated to many clinical settings of maternity care. Traditionally, many midwives have experienced a sense of being trusted by other midwives, their supervisor or obstetrician colleague through being credited with certain knowledge or behaviour that will be applied in particular situations. The predictability of clinical decision making based on an individual's knowledge of practice and protocol, coupled with their presumed competence and ability is, for the most part, assumed and expected.

Knowledge-based trust in maternity care requires a level of familiarity and understanding of the other person and their capacity to perform in practice and this can only occur over time. The better people communicate and know each other the more accurate they will be able to predict what the other will do. Importantly, this predictability enhances trust, even if the person is predictably unreliable because the ways that they can violate trust can be predicted (Boon and Holmes, 1991).

Identification-based trust involves both parties appreciating and understanding each others skills, values, actions and preferences such that each can effectively act for the other (Boon and Holmes, 1991). Clearly this form of trust could emerge between two midwives or obstetricians who wish to represent each other or to substitute for each other in a clinical sense as in the case of a practice partnership. In mainstream contemporary clinical practice settings this is more applicable in regard to actual tasks or specific skills rather than complete roles, for example the midwife completing a clinical procedure that is more usually the domain of the obstetrician.

In any relationship trust evolves and changes over time. Not all relationships develop fully and many professional relationships in health care services do not advance beyond a very preliminary and superficial perception of trust. Putnam (1993) has demonstrated that social capital is indispensable to the responsiveness and smooth functioning of civic institutions with low levels of interpersonal trust correlating with well low levels of confidence in institutions (Putnam, 1993). What emerges from this understanding of trust is that without it, relationships cannot develop. Without a relationship there is no possibility of collaboration. Critically,

without collaborative trusting relationships the potential to improve health care and maternity care in particular is severely limited and, I would argue, professional capital will not develop.

There are benefits that can emerge from positive professional networks and affiliations, including the capacity to improve the functioning of individuals and members of the health care team. This in turn can lead to new and creative ways of working that may not only benefit women as users of the services, but other stakeholders as well. For this reason, I have proposed that linkages exist between the development of what I call 'professional capital' for midwives and effective leadership and collaboration and that an understanding of this is central to addressing the invisibility of midwifery within mainstream maternity service provision.

5.4 PROFESSIONAL CAPITAL

The field of social epidemiology contains a rapidly expanding body of literature relating to social capital and social cohesion (Putnam, 1995; Kawachi, Kennedy, Lochner, Prothrow-Smith, 1997; Kawachi and Kennedy, 1997; Baum, 1999; Commonwealth Department of Health, 1993; Sainsbury, 1999; Leeder, 1999; Achat, Kawachi, Levine, Berkey, Coakley, Colditz, 1998; Kawachi and Berkman, 2000). My analysis of this literature has provided the basis upon which to build some ideas around the concept of what I call 'professional capital' in midwifery.

'Professional capital' is a construct that describes the potential enhanced capacity that midwives could experience if their work was understood, visible, recognised and valued in the provision of maternity services in Australia. By raising the professional capital and creating positive social networks and affiliations amongst midwives certain benefits may emerge. These benefits include the capacity to improve functioning of individuals, networks and relationships that in turn can lead to new and creative ways of supporting and strengthening interpersonal relationships. Professional capital is 'productive' (Coleman, 1988), which may make possible certain professional achievements and outcomes for midwives that might not otherwise have been possible. Professional capital may be a by-product of improving the professional relationships (Achat, Kawachi, Levine, Berkey, Coakley, Colditz, 1998) that exist between obstetricians and midwives.

Social scientists recognise that a society is not merely the sum of its individuals. So too the society [profession] of midwives consists of diverse needs, wants,

aspirations and multiple other characteristics. This portfolio has identified the role and scope of practice of the contemporary midwife and revealed the barriers that exist to their capacity and potential to make a major contribution to maternity care in Australia. It is recognised that currently the number of midwives in Australia is deficient and that the average age is 40.2 years (AHWAC, 2002). Multiple strategies that require significant leadership and guidance are necessary to ensure the improvement, not only in standards of education, regulation and practice (Brodie and Barclay, 2001; Brodie, 2002; Leap, Barclay, Sheehan, 2003a), but also the retention of the existing workforce (Leap, Barclay, Sheehan, 2003b). I suggest that these strategies are all linked to improving professional capital in midwifery.

James Coleman was one of the first social scientists to attempt a formal definition of social capital, describing it as consisting of those features of social structures that facilitate the actions of members within them (Coleman, 1988). According to Coleman, social capital like other forms of capital is productive, making possible achievements and outcomes that would not be possible without it. It is here that I make one of several linkages with some theories on collaboration which are described as not passive, but purposive relationships between individuals, that involve actions that are supposed to produce something (Schrage, 1990; Hardy, Lawrence, Phillips, 1999). Like collaboration, social capital is a feature of the collective (group, neighbourhood) to which the individual belongs, usually arising as a by-product of the social relationships (Kawachi and Kennedy, 1997). Professional capital in midwifery can therefore emerge and be enhanced through the development of unity and cohesion of the profession and the development of satisfying professional relationships. This unity and cohesion however cannot develop without coordinated and organised leadership and greater visibility of midwifery in the community.

Professional capital may be the result of efforts to increase trust, self-esteem and self-confidence in individual midwives, which in turn creates opportunities for new learning, fresh challenges and changes to practice, leadership in organisational systems and the culture of the workplace. By developing professional capital the capacity of individuals to work, provide care, and practise in a more confident and open manner, might expand. This could be enhanced by a willingness and a degree of professional generosity that is rare and desperately needed in traditional settings (Kirkham, 1996; Kirkham and Stapleton, 1999a). Through the provision of a positive professional working environment, the practices of midwives and others may be enhanced which in turn may improve the outcomes of the care provided to women.

Enhancing professional capital may also increase the midwife's capacity to experience greater autonomy and job satisfaction (Stafford, 2001; Walsh, 2000). Linking greater autonomy and increased job satisfaction to recruitment and retention of midwives in the workforce appears self-evident. However, the concept of raising capital is not meant to be another of Witz's 'professionalising projects' (Witz, 1992). Witz's work involved the adoption of a number of strategies to ensure a professional monopoly over the provision of certain skills and competencies that lead to occupational closure, a process similar to that of social closure in class formation which was by described by Parkin (Parkin, 1974). In contrast professional capital in its fullest form has the potential to open up, expand and develop the competencies and scope of practice of the midwife within the contemporary setting. Many might then be more able to fulfill the role and scope of practice already defined (International Confederation of Midwives, 1990) but too rarely seen in Australian maternity care (Brodie, 2002).

Another dimension of 'professional capital' emerges if we consider it as the 'currency of collaboration'. Collaboration in maternity care presents many opportunities in addition to those related to improving outcomes for women. If, through leadership, a degree of capital can emerge from positive professional networks and affiliations that lead to stronger collaborations, then the capacity and functioning of individual providers and the overall services can be increased. The type of shared decision-making that emerges from collaborative approaches to maternity care is only possible however, when the role and expertise of midwives is clearly recognised and overtly supported. The international definition of the midwife has been agreed to and formally adopted by the key peak bodies (International Confederation of Midwives, 1990) for over a decade. What is missing in the practice setting however, is formal recognition of the authority of the midwife and the inherent responsibility, accountability and legitimacy that comes with the role. The inter-relationship of midwives' responsibilities with those of medical staff is rarely clearly defined and this can be seen as a symptom of the current organisational patriarchal structures that reinforce obstetric power and give formal authority, status and responsibility to doctors, irrespective of their years of experience or knowledge. This invisibility and powerlessness of midwives is reinforced and virtually guarantees the continued erosion of their role through the medicalisation of maternity care (Garcia, Kilpatrick, Richards, (Eds), 1990). Within this milieu, the capacity for midwives to make a meaningful contribution to clinical decision-making and improving outcomes is impeded. By developing professional capital through greater understanding of

leadership and collaboration we may be more able to determine what is required to do things differently (Sheer, 1996).

This may further explain some of the positive attributes of the personnel employed in organisations described as 'magnet hospitals' (McKee, Rafferty, Aiken, 1997). Magnet hospitals are described as those that easily attract and retain nurses whilst providing 'above average' care and outcomes for patients (McKee, Aiken, Rafferty, Sochalski, 1995). Research conducted within forty one facilities identified as 'magnet hospitals' linked the key elements of effective inter-professional relationships and decentralised decision making with innovative leadership that enhanced the professional autonomy of nurses (Scott, Sochalski, Aiken, 1999).

The greater empowerment and professional 'freedom' (Friere, 1971) of midwives in leadership roles, gained through the acquisition of professional capital, may be a key to creating and maintaining positive clinical working environments and the development of 'magnet' maternity services in the future. Later in the epilogue I will propose that St George Hospital may be moving in this direction, namely as a magnet for midwives who wish to work in that particular culture of maternity care.

5.5 CONCLUSION

It is evident that competent, well-informed, strategic political leadership is necessary to ensure the determination of multiple ways of increasing the recognition of midwifery within the existing organisational culture of maternity care in Australia. New leaders are urgently required from midwives in practice, management, teaching and research roles. The challenge that exists for those who currently see themselves as 'professional champions' or leaders in midwifery, will be to sustain the effort required to ensure a number of transformational leaders emerge over the immediate and medium term. These leaders must be able to form alliances with women and work to influence government agendas to address the invisibility of midwifery at the social, organisational and political level. They must also lead and influence the development of collaborative relationships and systems whilst being cognisant of the power structures and hierarchical constraints that exist as barriers to their cause.

This portfolio has examined the lack of recognition of midwifery as an autonomous profession in Australia and its consequential invisibility in maternity care. What has been built is a comprehensive understanding of the reasons for this lack of visibility and the potential costs of such a situation continuing. Interventions that involve

focused and deliberate processes of leadership and collaboration that challenge existing systems and structures have been identified and tested but need more urgent implementation. This will contribute to the development of increased professional capital within the profession of midwifery, and enable it to become more clearly recognised and valued, and subsequently more effective in contributing to improving Australian maternity care.

Serious questions are being asked about midwifery in Australia and exactly what will be needed to achieve progress and address the invisibility and decline of the profession in this part of the world.

The answers lie within the portfolio, which include critical findings with serious implications for the future sustainability of Australian midwifery. A picture of a profession at a crossroads emerges, that necessitates the implementation of strategies and actions urgently needed at a local and national level to effect change and reorganisation. These initiatives include the development of national education standards for midwifery practice and changes to industrial, legislative and regulatory frameworks that recognise the midwife as a practitioner in her own right. The state and federal governments, the midwifery profession and other key stakeholders must also accommodate changing community and workforce needs and ensure the development of models of care based on evidence of the safety and cost effectiveness of midwifery. As governments and health services strengthen consumers' participation in health service planning, increased demand from informed women for greater choice and equity of access to maternity services, including primary care from midwives, can be expected. Within the context of global shortages of midwives, midwifery models of care could be seen as one of several strategies necessary to retain and attract midwives to the profession.

Two systematic reviews (Hodnett 2004a, Hodnett 2004b) have raised the possibility of some unintended consequences of midwifery led care. This should be a matter for consideration for anyone involved in the provision of maternity services. The authors concerned direct us to the need for ongoing research to test these concerns. This portfolio suggests future studies should address more specifically the 'processes' of care, in particular the 'transitions' in care that occur when women require transfer from midwifery care into secondary or tertiary care.

This portfolio provides evidence that midwifery is marginalised in Australia and describes the consequences if such a situation continues. This is largely because doctors wish to maintain their position as the most legitimate providers of maternity

care and because the industrial and regulatory control of the professional practice of midwives has remained under the responsibility and discretion of nursing organisations. This has occurred despite significant and ongoing efforts from a number of dedicated, concerned and committed midwifery activists over several decades.

There is a need for research that looks at the experiences of the different care providers, including the communication and networking patterns that enhance or restrict collaboration and team working. The consequences of the specific operational systems and structures and the 'processes' that are set up initially, as well as the level of advocacy, leadership and support that is ongoing, are all factors that can ensure long-term sustainability of the models of care. Policy and service leaders need to be informed by the experiences of others as well as the emerging evidence that encourages the expansion of midwifery in Australia. Well-constructed research that reflects the complex multi-professional nature of maternity service provision, whilst recognising the autonomy of the midwife, will further enhance the potential for better care of women in the future.

The dominance of medicine and a strong 'nursing' leadership culture, coupled with the lack of a highly visible and coherent political voice for midwives, are reinforcing and sustaining the invisibility of midwifery. The need for well-informed and skilful midwifery leadership that engages in collaborative relationships with consumers, doctors, nurses and others at local, systemic and wider political levels is clear. The resultant professional capital that emerges from within the ranks of individual midwives, groups of colleagues at the workplace and collective organisations such as the Australian College of Midwives (ACMI) will be the fuel that drives the vehicle of reform. If ACMI is to be seen as a strong, important and highly visible professional force, many more midwives will need to contribute to an emerging professional consciousness and become more politically active and involved. This will need emancipatory education that uses evidence and international experience to assist in the development of a clear and visible image of what midwifery 'is' within Australian society, so that communities, governments and funding bodies are able to recognise and appreciate midwifery's potential. It will also require significant funding to support the ACMI as an organisation that is responsible for the leadership of the profession.

Professional capital is a key to increasing midwives' professional status, confidence and self worth, but clearly whilst it may theoretically be available to all members of the profession, the extent to which individual midwives may be able to access it will

be unequal. It will be necessary for many to draw upon collective resources to do what they cannot do alone. Midwives who are not members of the College or part of services and organisations that are taking up the challenge to reinvigorate midwifery and build professional capital will need bridges with which to link in with those who are doing so.

It is critical that midwifery maintains, strengthens and makes visible a well-defined professional identity, whilst developing collaborative and consultative systems of care that focus on women's needs. Whether professional capital is the framework and scaffolding of a stronger, sustainable and more visible midwifery profession or the consequential outcome of improved education of leaders and better systems that midwives experience, is uncertain.

The nexus of the necessary leadership-led recovery of midwifery lies in the hearts and minds of midwives themselves. Conceptualising midwifery as a profession that must urgently capitalise on its inherent qualities, attributes and potential is the first step in bringing this to life.

6.0 EPILOGUE

As I write the closing words of this dissertation I am compelled to reflect on the personal journey I experienced throughout its construction. I originally set out to explore and interpret aspects of Australian midwifery that were of concern. In particular, I focused on the fact that the continued invisibility of midwifery in Australian maternity care had negative consequences in terms of outcomes for Australian women. Further, I believed that there were strategies that needed to be implemented to increase the recognition and contribution of midwives in order to address the problem. These strategies involved specific processes of leadership and collaboration that would maximise midwifery's contribution to maternity care and influence the development of professional capital in midwifery, which is necessary to improve maternity care.

My concerns about declining standards of midwifery education and regulation were compounded by a growing awareness that there was little being done by way of leadership, to reverse what appeared to be the demise of midwifery. For this reason, towards the completion of the professional doctorate, I made some major decisions that changed the course of my career.

In mid 2002, as the AMAP project was nearing completion, I was invited to accept a position as Senior Policy Analyst at the State health department. This position was created for me to work in the capacity of Maternity Services Advisor, providing policy and strategic leadership for the state. The need for the new role had emerged from a growing awareness within the health department, as well as concerns raised through various lobbies, that maternity services needed focused leadership and direction. Using the Maternity Services Framework (Appendix D) as the foundation, I was charged with the responsibility to advise, inform and guide the planning and priority setting for 'workforce' and 'models of care' in particular.

At this time, I was well over half way through the doctoral work, and was theorising about potential solutions to the 'problem' under study. I knew that professional capital was a key to the development of a stronger, more visible midwifery profession. All of the work that I was doing for the State health department reflected this position. The written documents I prepared, including the ministerial briefings, summations and reports, all cited the evidence and best practice principles, including primary health care, that substantiated such an approach.

Over a six-month period, I conferred with the range of policy advisers and bureaucrats whose work related in any way to maternity services. This included branches representing Aboriginal health, mental health, child and family health, medical workforce development, service planning, safety and quality, consumer relations, risk management and the nursing and midwifery workforce unit. Through a collaborative process and many iterations and rewrites, I prepared a document that became adopted as the policy direction for models of maternity service provision across the state (Appendix I). This was an exciting opportunity to lead and influence changes that will, over time, benefit women in terms of outcomes, and midwives in terms of greater recognition of their skills and contribution. The 'Models' paper (Appendix I) was circulated for comment to service leaders across the state in January 2003 and became adopted and endorsed as policy in May 2003.

During this period, I continued as the President of the midwives' professional association. I did my best to identify any conflicts of interests as they arose. These mainly occurred when I sought to promote 'midwife' in situations where I needed to promote the 'maternity care provider' in government policy. I saw this as crucial and agreed with it at the time, as a way of upholding the collaborative approach. As a strategy, whilst it looked on the surface as simple political correctness, it was central to getting others to engage with the ideas being put forward. Being inclusive [and not exclusive] of all care providers was important in the role that I had, as well as in the writing of the models of care paper. I had many debates and challenging discussions and, whilst I resisted at first, I did come to agree with the subtle messages [about midwifery] being interwoven and embedded rather than overtly stated. I was satisfied with the final paper and it is being held up as a significant contribution to contemporary maternity service planning.

Prior to the paper being circulated, I experienced a profound and deeply personal dilemma regarding the uncertainty of my professional working life. I had been a full time researcher with the AMAP project for three years, followed by six months as the Maternity Services Advisor. This was nearly four years of being completely removed from clinical practice. In the role as Maternity Services Advisor I had also become a 'bureaucrat'. As a 'bureaucrat' it was difficult to be a midwifery leader. As a midwifery leader, it was difficult not being in any way connected to practice. I decided that I had to choose one or other role. After much contemplation and seeking of wise counsel, I decided that I needed to be back in clinical practice. The day that I made that decision I also decided that I wanted to return to the facility where I had previously been employed, developing community based maternity

services. From my experience I knew that this facility was unique and that the mutual support and shared philosophical beliefs of the individuals involved was a crucial factor in the ongoing pursuit of organisational cultural change and systems reform.

My experiences in developing the STOMP model (Case Study One) were such that I knew that the facility was on the right track in achieving improved systems and models of care, and in recognising midwifery. Whilst the membership of the 'team' of midwives, doctors and service leaders would no doubt have changed, I was keen to explore how sustainable the earlier innovations and changes had been. I made the decision that I would return and phoned a colleague. To my complete surprise I was informed that there was a leadership position currently being advertised – as Birthing Services Coordinator. This involved the day-to-day support of midwives working in the Delivery Suite, the Birth Centre and the two STOMP teams. Given the journey that I was on, I felt that this was perfect timing for me and I was immediately thrilled with the prospect of returning to 'real midwifery'. I commenced working in the new position in January 2003.

In August 2003 the State government held a one day workshop with obstetric and midwifery leaders from across NSW [over 100 in total] to lead and further progress the work in developing a range of models of care, under the direction set out within the 'Framework' document (Appendix D) and the 'Models of Maternity Service Provision' document (Appendix I) . Specifically, this workshop focused on the widespread introduction of primary models of care in maternity services and the need for recognition and incorporation of the evidence that supports midwives as primary care providers. I was asked to present a paper outlining the key components of the evidence and to provide further explication of how service leaders could 'operationalise' the new models of care. I remember during the presentation how I felt, speaking this time as a clinical practice leader, based within a 'real' maternity unit. This contrasted starkly with my earlier experiences of attempting to convince those in service provision [of the need for change] when I was based within the health department. I concluded that, at least for this period of my career, I was more likely to influence changes and lead by example, if I was based within clinical service provision.

Currently, at the facility where I am employed, there is a clear and overt expression of support and recognition of midwifery. Strong leadership in this regard continues to be provided by the Obstetric Head of Department and the Midwifery Director. Both

of these positions are critical in my view. Models of continuity of midwifery care are well developed and accessed by more than 65% of all women who book in this hospital. The organisational culture supports midwifery as a profession in its own right, employing many midwives who are not nurses. It is one of the few hospitals that is not experiencing an extreme midwifery shortage at this time. It is evident that midwives seek employment here because of the strong culture of midwifery and the opportunity to work to the full scope and practice according to the International Definition of a Midwife (International Confederation of Midwives 1990 579 /id).

It is early days yet with regard to measuring the flow on effects of the changes in this facility. The models of care that have developed over the past seven years are clearly well supported and appreciated by the women. The challenges that lie ahead centre on continuing to develop midwifery continuity of care models, and improving clinical practices and the outcomes for women and babies. The aim is to improve the individualised care and experiences of women so that outcomes, in particular spiralling rates of intervention, can be improved upon. I am confident that the ongoing commitment to develop effective leadership and collaboration in this maternity unit will demonstrate an increase in the professional capital of midwives.

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8.0 APPENDICES

APPENDIX A: THE AMAP 'GRAFFITI SHEET' SURVEY



Australian Midwifery Action Project (AMAP)

AMAP – is an action research project set up to review issues around midwifery. In particular, issues such as shortages of midwives especially in rural and remote areas, and concern from midwives and nurses about the 'way forward' for midwifery and nursing in Australia. The project is funded through a Strategic Partnerships with Industry Research and Training project in collaboration with the Australia Research Council.

Midwives are the largest single group of health workers in the maternity care system, and yet, no comprehensive analysis of Australian midwifery policies is available. Policy and planning is constrained by divisions within and between the professions of midwifery, nursing and medicine, and by inadequate communication between stakeholders involved in maternity care.

Please have your say on this important project. Remember your reply remains anonymous and confidential. You may add (one) additional page if you wish. Post replies to **AMAP Research Project, UTS, PO Box 123, Sydney 2007**

or go to

[www.centre for family health and midwifery](http://www.centreforfamilyhealthandmidwifery.org.au) and follow the signs to **AMAP**

Indicate any or all of the following that best describes your situation.

Mother

CM/RM

Practising midwife

Pregnant

Other (Please specify)

What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia?

What are the strategies to overcome these?

THANKYOU FOR YOUR PARTICIPATION

APPENDIX B: LIST OF THE TOWNS, CITIES AND REGIONAL LOCATIONS FROM WHICH THE AMAP ‘GRAFFITI SURVEYS’ WERE RECEIVED.

- Adelaide
- Albury
- Alice Springs
- Brisbane
- Cairns
- Darwin
- Hobart
- Kalgoorlie
- Launceston
- Melbourne
- Perth
- Rockhampton
- Sydney

APPENDIX C: TERMS OF REFERENCE FOR THE THREE ORGANISATIONS IN CASE STUDY TWO

Organisation A: The Outpatients Department of an urban tertiary hospital

TERMS OF REFERENCE

Objectives

- Evaluate existing models of care and type of service provision in terms of client focus, throughput, continuity of care, number of visits, average duration of visit, number of different carers.
- Identify the staffing patterns and workload in the various clinics: Obstetric, Midwifery and Gynaecology Clinics.
- Observe and describe midwifery practice and the role of the midwife in the Midwifery, Obstetric and Gynaecological Clinics.
- Determine current views and attitudes of staff working the ZZ Outpatient Services Department.
- Identify strategies to improve efficiency and effectiveness in delivery of service from ZZ Outpatient Services Department, including any 'system' problems e.g. interface with Pathology or Imaging Departments.

Outcomes

- An analysis and recommendations regarding current staffing and activity levels in the ZZ Outpatient Services Department.
- Recommendations regarding the midwifery models of care in the Midwifery and Obstetric Clinics based on current evidence and best practice.
- An evaluation of midwifery practices within the ZZ Outpatient Services Department and recommendations for developing midwifery care that reflects care based on current evidence and best practice.

Organisation B: Maternity Services across a rural health service

TERMS OF REFERENCE

Objectives

- Review the profile of service delivery for the area health service (AHS).
- Review variation in childbirth practices between hospitals within the AHS in particular, intervention rates (i.e. inductions, caesarean birth, episiotomy and epidural anaesthetics). Compare with State and professional benchmarks.
- Review perinatal and maternal mortality and morbidity rates and compare with State and professional benchmarks. Clinical outcomes to include those associated with transfers within and external to the AHS.
- Review access to information and education for expectant mothers and their families.
- Review choice and cultural appropriateness of current models of care.
- Review protocols and practices associated with Early Discharge programs.
- Review the last 2 years critical events involving women >20 weeks gestation.

Performance Indicators

- All the ACHS clinical indicators where appropriate.
- Antenatal care - Numbers of who provides care
- - Clinic numbers
- Number of transfers and outcomes of each
- Breastfeeding rates at 4 and 6 months
- Women's satisfaction with their antenatal / birth / postnatal experience

Organisation C: A small rural maternity service

TERMS OF REFERENCE

Objectives

- Review the current midwifery / nursing practices relating to ante natal, obstetric and neonatal services at XX District Hospital ('the larger unit')
- Identify areas of improvement in midwifery / nursing service delivery relating to ante natal, obstetric and neo natal services at XX District Hospital
- Outline a framework for the development of a coordinated approach to antenatal, obstetric and neonatal nursing services at YY ('the larger unit') and XX District Hospitals within the anticipated role delineation

Specific Issues for Review

- Identify and prioritise (maternity) nursing service gaps at XX Hospital
- Assess the scope and appropriateness of current models consistent with current and anticipated role delineation and service demands.
- Identify and make recommendations relating to the establishment of an antenatal clinic at XX Hospital
- Review of the Early Discharge Program
- Assessment of nursing policies, protocols and staffing relating to the Special Care Nursery
- Recommendations relating to Midwifery Skills Development
- Recommendations relating to the introduction of a Trainee Midwives Program

APPENDIX D: THE NSW FRAMEWORK FOR MATERNITY SERVICES

**THE NSW FRAMEWORK FOR
MATERNITY SERVICES**



MATERNITY SERVICES ADVISORY COMMITTEE

APRIL 1999

TABLE OF CONTENTS

ACKNOWLEDGMENT

This report represents a collaborative effort of a number of individuals representing maternity health service providers, consumers, policy makers, clinicians and professional organisations. The NSW Maternity Services Advisory Committee was convened by NSW Health Department to address some important challenges in maternity care. The Committee discussed, debated and exchanged knowledge, experiences and opinions regarding maternity services across New South Wales in the context of national and international trends and were able to reach consensus on a wide range of important issues and strategic directions for future maternity services in NSW.

We gratefully acknowledge the efforts of all members of the NSW Maternity Services Advisory Committee:

Dr Andrew Wilson	Deputy Director-General, Public Health (Chairperson)
Ms Pat Brodie	Midwifery Consultant (Project Officer)
Ms Judith Meppem	Chief Nursing Officer
Ms Kathy Meleady	Director, Statewide Services Development Branch
Dr Steevie Chan	Manager, Clinical Services Planning Unit
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Dr Marie-Louise Stokes	Policy Officer, Clinical Policy and Practice
Ms Lynette Pugh	Senior Policy Analyst
Ms Dare Kavanagh	Project Officer, Women's Health
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Mr Dennis Moulds	Rural Midwifery Consultant
Dr Andrew Child	Obstetrician and representative from Tertiary Maternity Hospitals
Prof Michael Chapman	Professor of Obstetrics & Gynaecology (Academic)
Prof Marie Chamberlain	Professor of Midwifery (Academic)
Dr Penny Knowlden	Royal Australian College of General Practitioners
Prof William Walters	Professor of Obstetrics & Gynaecology (Chairperson, NSW Maternal and Perinatal Committee)
Dr Michael O'Connor	Royal Australian and New Zealand College of Obstetricians & Gynaecologists (until August 1998)
Dr Vijay Roach	Royal Australian and New Zealand College of Obstetricians & Gynaecologists (from August 1998)
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Thanks are also given to individuals in Area Health Services who responded so thoroughly to requests for information.

EXECUTIVE SUMMARY

The NSW Maternity Services Advisory Committee was convened in November 1997 to develop a collaborative approach and strategic direction for providing maternity services over the next five years. This report, *The NSW Framework for Maternity Services*, is the result of the deliberations of the Committee following its assessment of current services and issues. A review of the contemporary literature was used to inform the development of this report.

Maternity services in New South Wales continue to be developed and refined in order to promote the best possible health outcomes for women and their babies. Since the release of the Shearman Report¹ in 1989, a large number of initiatives have been well received by women and have led to significant improvements in both clinical effectiveness and overall satisfaction with maternity care.

A range of issues affecting the provision of integrated maternity services have been identified as requiring attention at both Departmental and Area Health Service levels. A number of major recommendations have been made in attempting to address specific issues that have been highlighted as being of significant concern to consumers, health professionals and the NSW Health Department.

Differing attitudes, values and practices among midwifery and obstetric care providers within particular maternity units may influence the clinical effectiveness and cost-efficiency of those units as well as consumer and staff satisfaction. Given the importance of each of these factors to the provision of a quality maternity service, there is a need to ensure that midwives, obstetricians and general practitioners work within a collaborative and consultative framework which values the different yet complementary contributions of their respective roles. The ongoing education and training needs of all maternity health care workers continues to be an issue, especially in those units with low birth rates and minimal opportunities for staff to practise their clinical skills. This report provides strategies to assist Area Health Services in maintaining a skilled and competent workforce. Additional strategies, directed at longer term solutions are also suggested.

A range of necessary service changes have been identified which include:

- expanding the range of care models
- increasing the availability and accessibility of services, particularly for rural and remote communities
- improving the level and flexibility of available resources
- responding to consumer expectations.

It is generally agreed that further efforts are required to enhance the responsiveness of maternity services to the needs of women and their partners/families, particularly those from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds.

At the local level, unresolved professional indemnity issues affecting midwives and doctors, together with existing funding systems and industrial relations structures, have in many instances acted as disincentives to the attainment of new directions in maternity care. Other maternity service workforce issues have been assessed in detail and within the context of a recent national review of the obstetrics and gynaecology workforce. A slight shortage of obstetricians and gynaecologists exists, primarily because of a maldistribution between rural and metropolitan locations. However, a more challenging situation involves the number of midwives employed in the Area Health Services, and a range of strategies are identified that require urgent implementation.

The NSW Framework for Maternity Services provides strategic objectives for the development and implementation of future services. Meeting these objectives will require focused attention and concerted action on the part of all key stakeholders. The need for collaboration and consultation between service providers and consumers to better determine needs and priorities is paramount. This will be critical to ensuring that services are safe, efficient and effective, as well as respectful, personalised and rewarding for all concerned.

It is important that the five-year goals, objectives and strategies are used in conjunction with the body of this report to move forward on the important task of planning and implementing maternity services that are flexible and responsive to all women in NSW.

MAJOR RECOMMENDATIONS

For *The NSW Framework for Maternity Services* to achieve its primary purpose of providing structure and direction for the future development of maternity services, a number of recommendations will require implementation in the first instance. These include that:

1. NSW Health adopts the five-year goals, objectives and strategies of *The NSW Framework for Maternity Services* and implements these through the Area Maternity Services Plans.
2. NSW Health adopt the following philosophy statement for developing maternity services:
 - NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.
 - Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate.

- Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.
3. The NSW Health Department allocate designated resources within the Department to coordinate and oversee the implementation of *The NSW Framework for Maternity Services*.
 4. The NSW Health Department review “early discharge programs” across NSW to determine their effectiveness and appropriateness, as well as the consistency of service guidelines, policies, terminology and reporting mechanisms. This should include evaluating the needs and priorities of women in accessing early discharge programs and the effectiveness of referral and follow-up procedures, particularly for women from marginalised or disadvantaged groups.
 5. The NSW Health Department evaluate women’s views of maternity care, including those of women from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds, with particular attention to addressing the specific needs of women from marginalised or disadvantaged groups.
 6. The NSW Health Department initiate a project to improve Aboriginal and Torres Strait Islander perinatal health outcomes, including identifying contributing factors, practical service provision strategies, best practice initiatives and evidence-based approaches.
 7. The NSW Health Department address current issues within Area Health Services that affect the provision of homebirth as a safe and effective choice. These issues include:
 - a review of perinatal deaths associated with homebirth in NSW
 - accreditation of independent and visiting midwives
 - protocol for homebirth transfer
 - review of the NSW Homebirth Policy Statement
 - increased participation of independent and visiting midwives in staff development, peer review, quality assurance and clinical case review meetings.
 8. The NSW Health Department resolve the issue of medical indemnity for visiting obstetricians in public health services.

BODY OF REPORT

Introduction

Maternity services in New South Wales continue to be developed and refined in order to promote the best possible health outcomes for women and their babies. Since the release of the Shearman Report¹ in 1989, a large number of initiatives have been well received by women and have led to significant improvements in both clinical effectiveness and overall satisfaction with maternity care.

This report outlines the strategic directions for NSW maternity services for the next five years. It summarises a process of consultation and review about a range of professional, service and consumer issues relating to the provision of maternity services in NSW. The issues discussed in this report build on and reflect matters raised by metropolitan and rural Area Health Services, obstetricians, midwives, professional organisations and the NSW Health Department in previous consultative forums, reports and professional literature. The report incorporates the strategic directions for NSW Health as outlined in *Strategic Directions for Health, 1998-2003, Better Health, Good Health Care*.²

Since 1989, three comprehensive reviews (*Maternity Services in New South Wales—The Final Report of the Ministerial Taskforce on Obstetric Services in NSW*, known as the Shearman Report¹ *Options for Effective Care in Childbirth*³ and the *NSW Midwifery Taskforce Final Report*⁴) have been conducted to consider, among other things, the implications of changing models of midwifery and obstetric practice for maternity service provision and consumer outcomes. The findings of each of these reviews have confirmed the need for midwifery and obstetric services to work within a collaborative and consultative framework to achieve positive health outcomes for consumers and a closer matching of services to consumer needs, preferences and expectations.

In November 1997, the NSW Maternity Services Advisory Committee was convened to develop a systematic approach to maternity service provision across NSW. The Committee's Terms of Reference were:

1. To develop a framework for implementing collaborative obstetric and midwifery practice across the continuum of maternity care, addressing issues relating to:

- models of care
- cultural awareness and sensitivity
- public and private sector collaboration
- consumer needs and choices.

2. To assess, evaluate and formulate options for improved management of human resources in delivering maternity services, addressing issues relating to:

- education and training
- professional indemnity
- independent midwifery accreditation/privileges
- collaboration between professional and collegiate groups
- rural and remote issues.

The principal objective for contemporary maternity services is to ensure choice, control, continuity of care and safety for all women in all phases of pregnancy and childbirth. This remained the basis for discussion and decision-making throughout the Committee's deliberations.

The Committee reviewed information from a number of sources including:

- current national and NSW reports that inform the development and delivery of maternity services (References and Bibliography).
- information provided by Area Health Services in response to the *Status Report – Maternity Services*, a survey undertaken to provide a profile of current maternity services (Appendices A and B)
- NSW Health departmental policies and circulars and other documents relating to maternity care
- discussion and debate between Committee members about a wide range of professional, service and consumer issues in maternity services.

Current Initiatives in NSW Health

Initiatives undertaken recently by the NSW Health Department which specifically or generally address the challenges experienced in maternity care include:

- the NSW Maternal and Perinatal Committee
- negotiating Performance Agreements between Area Health Services and the NSW Health Department
- the Rural Health Workforce Strategy
- perinatal seminars in rural health services
- funding initiatives through Alternative Birthing Services and National Women's Health Programs

- the Pilot Locum Service for rural obstetricians and gynaecologists
- Midwives Data Collection
- *consultative forums with health services, professional organisations and educational providers regarding midwifery services*
- consultation and review of medical indemnity for obstetricians in public health services
- developing maternity emergency guidelines for registered nurses
- funding of refresher midwifery programs
- transitional support funding for new graduate midwives
- development of guidelines and service models for Ethnic Obstetric Liaison Services.

The Range of Maternity Services in NSW

NSW Health provides a range of maternity services to the community through the metropolitan and rural Area Health Services.

When considering the nature and scope of the maternity services available to the local population, it is evident that there is considerable variation within, as well as between, Area Health Services. Differences can arise from a number of factors including:

- geographical location
- demographic profile
- health workforce supply
- access to transport
- role delineation of local hospitals, including the level and mix of primary, secondary and tertiary services available
- appropriate utilisation of a skilled maternity workforce
- the extent of other support networks.

To determine the current status and range of services, a survey was conducted of all Area Health Services (*NSW Health Status Report – Maternity Services*, Appendix A). From the survey results, profiles of maternity services across the State were developed which assisted the Committee in determining the currently available services and systems of care. The *New*

South Wales Maternity Services Status Reports (Appendix B) contain the resulting profiles for each Area Health Service.

The range and variation of services and systems of care reported in the *New South Wales Maternity Services Status Reports* reflects the uniqueness of each facility; however, the Committee considered that a number of services or systems should be essential to *all* facilities providing maternity care. These are included as a checklist in the *Status Reports* and provide a useful, quick reference for each Area Health Service to determine possible gaps in services, systems or policies. In particular, the Committee was concerned that systems should ensure adequate collaboration and consultation between consumers and members of the maternity health care team. Such systems are important in ensuring a seamless service and transition through the system and the best possible outcome for women and their babies.

It is important that all women are fully informed about the range of available maternity services. Maternity care providers have a duty to ensure that women receive sufficient information to make informed decisions about an appropriate birth setting and carer and about their preferred type of birth and subsequent care, as well as to know about the risks, benefits and indications for those choices. To this end, it is timely to reconceptualise the role, purpose and priorities for childbirth education services of the future.

The Maternity Services Advisory Committee was informed of the need for services providing information and advice about the use of medication in pregnancy and lactation. A number of initiatives are being explored at Area Health Service level and the committee offered in-principle support to the concept of developing a statewide service.

The overall picture of current maternity services across NSW provided by the profiles in Appendix B is one of a comprehensive system of services with a range of models of care being provided by a number of different types of health professionals. However, these models are not universally available, and the range of choices is greater in metropolitan than in rural and remote areas. Moreover, within some Area Health Services, there are some inconsistencies between facilities concerning their approaches to service delivery. In spite of similar geographic and demographic profiles, there are a number of gaps in services and systems of care within Area Health Services that need to be addressed at the local and area levels. The strategic plan within *The NSW Health Framework for Maternity Services* provides a number of objectives and strategies designed to assist in addressing these issues.

Choice and Access Issues

Maternity early discharge

Early discharge programs were the focus of extensive discussion within the Committee. Discussions were held regarding the variable structures, systems and processes of each program and the need for any evaluation of the efficacy and appropriateness of the programs across NSW. The quality and quantity of information provided through the *New South Wales Maternity Services Status Reports* (Appendix B) has highlighted variances in criteria, protocols and terminology in use, as well as the lack of any consistent format for reporting activity and utilisation of the early discharge option.

Increasingly, early discharge is becoming standard practice in many units. Consequently, the lack of data to ascertain an accurate impression of the activity of this service has significant implications. Importantly, there is no evaluation tool to identify issues of concern to women regarding this practice, including the level of satisfaction or suitability for the majority. *The NSW Health Framework for Maternity Services* attempts to provide some objectives and strategies to address these issues in the context of quality improvement and meeting the needs of consumers and the community.

Homebirth Services

The Committee considered the model of care for women requesting homebirth. NSW Health acknowledges that women have the right to choose the place of birth and it is recognised that some women will choose homebirth. Therefore, it is important that Area Health Services develop appropriate policies and standards of care to minimise risk to mother and baby in the event of unforeseen complications requiring transfer to hospital. There is a responsibility on the part of the provider of care for home births to inform the woman of both risks and benefits of homebirth. Issues of preferred referral if clinically required, availability of adequate back up facilities and medical cover should also be discussed. It is the responsibility of the provider of care for homebirth to ensure maintenance of clinical competence through professional education and peer review.

The accreditation of independent midwives to practise in hospitals was a major recommendation of the Shearman Report ¹ and the responsibility to instigate this process was delegated to the Area Health Services. To date eight of the 17 Area Health Services report the existence of protocols in some of their facilities. Work continues to expand these opportunities.

A number of issues were discussed by the Committee as a result of the publication of data relating to perinatal death associated with homebirth in Australia and the recent decision of the Nurses' Tribunal relating to the practice of an independent midwife. Particular matters relating to perinatal deaths in NSW were referred to the NSW Maternal and Perinatal Services Committee for review and advice on policy. It was agreed that mechanisms within

NSW Health need to be strengthened to allow women the choice of midwife or medical practitioner as the primary care provider for homebirth. In addition, specific service issues requiring attention within each Area Health Service have been addressed through *The NSW Framework for Maternity Services*. These issues include:

- the development of protocols in each Area Health Service enabling the accreditation of independent midwives as visiting midwives
- maintenance of essential minimum clinical skills in resuscitation and maternity emergencies for all maternity service providers
- review of the NSW Homebirth Policy Statement
- level of professional indemnity insurance for independent and visiting midwives
- protocol for care of a woman and/or her baby being transferred from a planned homebirth to hospital facilities
- increased participation of independent and visiting midwives in staff development, peer review, quality assurance and clinical case review meetings
- formal links and networks between Area Health Service-employed staff and independent and visiting midwives.

These matters were discussed by the committee and will be considered for inclusion in the revision of the Homebirth Policy, which is currently under way.

Women with additional needs

Providing accessible and culturally appropriate information and services to all women is a primary goal of NSW Health, and one that is critical to achieving desired health outcomes.

This is of particular importance during pregnancy for Aboriginal and Torres Strait Islander women, non-English speaking background (NESB) women, young women and women at psycho-social disadvantage because of the associated higher rates of perinatal mortality and morbidity.

That these groups of women have special needs in relation to maternity services has been confirmed by the three maternity services reviews referred to earlier.^{1,3,4} Those reviews emphasised the importance of ensuring that maternity services are responsive to the different culturally determined assumptions and expectations of individual women and their families, and that the models of care and available birthing options provide choice, facilitate access, enhance health outcomes, and promote consumer satisfaction. In addition, the need for all staff to attend cultural sensitivity training and increase their awareness of the needs of individual women was highlighted.

The health status of Aboriginal and Torres Strait Islander people is compromised at all stages of life. In 1996, the perinatal mortality rate in babies born to Aboriginal and Torres Strait Islander mothers was 17.4 per 1000, about double the rate of 8.9 per 1000 for NSW overall.

Apart from the stress of leaving their families to give birth in the nearest hospital, other factors that can present great hardship for pregnant Aboriginal and Torres Strait Islander women are the costs associated with transport, accommodation and childcare. If appropriate models of care are to work effectively, these associated issues need to be addressed to ensure that women not only have access to, but are supported in accessing, a full range of services.

The Shearman Report recommended a number of strategies regarding access and culturally appropriate maternity services for Aboriginal and Torres Strait Islander women. These included:

- expanding shared care arrangements between maternity units and Aboriginal Medical Services
- creating Aboriginal Liaison Officer positions in hospitals serving large Aboriginal and Torres Strait Islander communities
- providing suitable pre-confinement accommodation attached to country hospitals for women from remote areas
- greater acceptance and involvement of traditional Aboriginal and Torres Strait Islander birth attendants

A key strategy implemented by the NSW Health Department has been to provide funding assistance to community-controlled Aboriginal Medical Services to enable them to offer alternative birthing services or to complement existing birthing services.

The NSW Alternative Birthing Services Program (Second Phase) funded five Health Services for one-off innovative initiatives. Area Health Services with the highest Aboriginal and Torres Strait Islander and infant morbidity and mortality were identified and incentive funds provided to address the structural and service issues that inhibited Aboriginal and Torres Strait Islander women's access to existing maternity services. Examples of projects funded include:

- outreach midwifery services to isolated or remote areas
- antenatal and postnatal services provided by a midwife and/or Aboriginal or Torres Strait Islander health worker
- work with young homeless Aboriginal and Torres Strait Islander women to facilitate their access to mainstream health services

- a cultural awareness program for service providers.

An evaluation of this program, *Evaluation of the New South Wales Alternative Birthing Services Program, Second Phase 1993/94–1996/97*,⁵ was completed in 1998 and all recommendations have been integrated into the five-year plan contained in *The NSW Framework for Maternity Services*.

In late 1998, NSW Health Department allocated \$80,000 from the Aboriginal Enhancement Program (Aboriginal Health Branch) to develop a number of practical strategies and protocols to reduce Aboriginal and Torres Strait Islander perinatal mortality. The key issues to be addressed by this project include:

- identification of factors contributing to Aboriginal and Torres Strait Islander perinatal deaths
- a review of practices which have successfully reduced perinatal mortality rates in indigenous communities in Australia and internationally
- an evidence-based approach to planning and services delivery for Aboriginal and Torres Strait Islander maternal and child health.

Planners of maternity services must work with leaders among local Aboriginal and Torres Strait Islander women to ensure that the services provided cater for the needs and expectations of those women. Encouragement and support should be given to enable Aboriginal and Torres Strait Islander women to become members of consumer liaison committees within maternity services. Opportunities for Aboriginal and Torres Strait Islander people to train as health workers, nurses, midwives and medical practitioners should also be energetically pursued.

Collaborative strategies that have the potential for a positive impact on the health and wellbeing of pregnant Aboriginal and Torres Strait Islander women, new mothers and babies include:

- pursuing and creating culturally relevant opportunities for education and information exchange regarding health and illness
- enhancing participation in community development programs that maximise Aboriginal and Torres Strait Islander women's personal involvement in decision-making regarding healthy lifestyles
- offering a support and liaison service for women with specific linguistic and cultural needs associated with pregnancy, childbirth and early parenting.

It is likely that members of local Aboriginal and Torres Strait Islander communities in some rural and remote areas of NSW will have a first language other than English. They may

encounter communication barriers when interacting with the State's health services, and their experiences may be similar to those of others from a non-English speaking background. To provide adequately for the needs and preferences of all, maternity services must be culturally sensitive in the broadest and most encompassing sense.

A good example of a best practice model for NESB women is the Ethnic Obstetric Liaison Officer Program. The Committee has considered the report, *Guidelines and Service Models for Ethnic Obstetric Liaison Services in NSW—A Summary Report*,⁶ and recommends it as a framework for ongoing development of these programs. Other initiatives to improve maternity care for NESB women need to be explored and *The NSW Framework for Maternity Services* identifies a number of strategies to assist in this endeavour.

Another group with particular needs within maternity services are young women. It is especially important to take into account the complex psychological, social and economic issues that can be experienced by this particular client group and the possible implications of these issues for the mother's and/or baby's health.

It is important that programs for pregnant and drug-dependent women are developed or continue to receive funding, particularly in areas with a high proportion of such women. Existing and proposed services should be responsive to the special medical and social needs of drug- and alcohol-dependent women by increasing the knowledge and awareness of health care providers regarding the relevant issues.

Other consumers requiring additional support and care are those women and families at extreme social disadvantage arising from poverty, isolation, lack of social support and/or homelessness. There is a convincing body of evidence that demonstrates that mothers and babies from disadvantaged groups are likely to have poorer maternity health outcomes than the population as a whole.

Women experiencing perinatal loss or relinquishing their babies for adoption, as well as those experiencing multiple births, may also require additional care and support that continues beyond the usual duration of maternity care. Service providers need to ensure women's access to the full range of services and community agencies to assist them and their families through these experiences.

Postnatal depression is a significant cause of maternal morbidity affecting 10 to 15 per cent of all new mothers. In 1994, NSW Health conducted a review of postnatal depression services and identified several major issues and a range of recommendations to assist the coordination of postnatal depression services across the state. Ongoing implementation of all of the recommendations from this report continues to be a priority.

The NSW Framework for Maternity Services provides a number of objectives and strategies to assist service providers to ensure timely identification of women at psycho-social risk during pregnancy and early parenting. Early detection and intervention for families

experiencing difficulties and the provision of more intensive assistance from a multidisciplinary team of carers will assist in reducing the difficulties and morbidity for this particular client group. Strategies aimed at improving formal links and communication between acute hospital services, Early Childhood Health and Aboriginal Medical Services are essential if transition back into the community for each mother and her baby is to be seamless and effective.

The NSW Government's Families First initiative aims to strengthen and extend the parenting skills of every parent in NSW who has a child under eight years of age. Announced in May 1998, Families First is a government-funded prevention and early intervention initiative to support families by providing them with the necessary knowledge, assistance and community networks to enable them to develop their parenting skills. The initial implementation of this program will commence in South Western Sydney, the Far North Coast and the Mid North Coast in 1998–1999. The Maternity Services Advisory Committee notes the initiative and recognises the important links that need to be developed between this program and maternity services to avoid overlap of services and to ensure continuity of care.

Workforce Issues

The NSW Health Department's 1996 Workforce Planning Study For Maternity Service Nurses, Adult Critical and Intensive Care, and Operating Room Nurses ⁷ and the NSW Midwifery Taskforce Final Report ⁴ highlighted a range of problems related to the recruitment, retention and education of midwifery students and midwives. Paralleling the recent decline in midwifery workforce numbers have been the growing difficulties experienced in recruiting and retaining obstetricians in rural/remote areas and a general shift among general practitioners away from providing obstetric care. These trends raise issues regarding the effective management and provision of maternity services across NSW and the availability of choice and access to a range of service options for the consumer.

Many factors affect the capacity to recruit and retain a midwifery and obstetric workforce and they need to be considered in the process of planning future maternity services. Such issues include:

- geographical location
- infrastructure and support for outreach services
- access to support services/staff
- family-friendly work practices
- opportunities for skills maintenance and development

- professional indemnity premiums
- the 'culture' in particular facilities
- organisational management issues
- the level of professional autonomy and skill mix of staff.

Medical Workforce Issues

The Australian Medical Workforce Advisory Committee (AMWAC) presented a report, *The Obstetrics and Gynaecology Workforce in Australia*,⁸ to the Australian Health Ministers Advisory Council in late 1998. The report concluded that, from a national perspective, there was a slight shortage of obstetricians and gynaecologists that was due primarily to maldistribution. The data is broken down by State, and rural and urban differences are reported. The report found that services provided by general practitioner obstetricians have decreased over the last decade, with 87 per cent of clients cared for by specialist obstetricians, and that there is increased growth in Medicare services. The report recommended that NSW should maintain intake numbers for trainees in obstetrics and gynaecology at the current level of 20 per year until 2002.

Other workforce issues affecting obstetricians and general practitioners and raised through discussion in the committee include:

- **Professional Indemnity**

Concerns have been raised regarding increasing difficulties associated with the rising costs of medical indemnity premiums, particularly for those working in obstetrics. It is recognised that this may be a disincentive to providing obstetric care and may impede future recruitment into the obstetric workforce. The NSW Health Department is currently examining the issue of medical indemnity, which affects visiting obstetricians providing care to public patients. This issue is also being discussed with the Australian Medical Association (NSW Branch). The Department aims to find a fair, practical and appropriate approach to the issues, with a resolution being sought in the near future. It is important that consumers are informed of the need to establish that their care provider has indemnity insurance, as the Committee was made aware that a small number of practitioners do not carry any insurance.

- **Decline in number of rural obstetricians and general practitioners**

The committee discussed the difficulties in attracting and retaining an adequate rural medical workforce in obstetrics. There are a range of contributing factors, including skills attainment and maintenance, economic disincentives and lifestyle factors, and the increasing trend towards sub-specialisation within the obstetric and gynaecology workforce. This, coupled with associated disincentives—for example, the long and unsociable hours of obstetricians

and indemnity issues, will affect ongoing recruitment. Strategies to address the increasing difficulties in finding obstetricians to provide adequate cover in base and larger rural hospitals will need ongoing exploration. The committee identified some alternatives, including the employment of career obstetric medical officers who meet standards set by RANZCOG, as worthy of further exploration.

- **Locum Relief for Rural Obstetricians and Gynaecologists**

A pilot program has commenced to provide short-term relief for rural specialist obstetricians and gynaecologists, with a view to retaining those specialists currently working in rural New South Wales and reducing the gaps in services. The pilot will run for six months until March 1999 and will enable specialists in one- or two-person practices to take leave for continuing education. The pilot project has commenced with the South Eastern Sydney Area Health Service and the Central Sydney Area Health Service coordinating locum relief for the Greater Murray and Southern Area Health Services. Feedback to date from the participants is positive.

Midwifery Workforce Issues

- **Certified Midwives**

The AMWAC report⁸ attempted to include midwifery and nursing workforce issues in its review process. However, it acknowledged that it was not possible to determine national midwifery workforce numbers because of the absence of reliable national data and problems with workforce planning methodology. The number of practising midwives in Australia is not known, nor is there any reliable mechanism established to monitor the situation. In NSW, data from a variety of sources indicates an under supply of qualified midwives in the workforce, with a consistently high number of midwifery positions being actively recruited. In particular, reports from rural and remote areas identify a shortage of midwives and increasing use of staff without midwifery qualifications. While there is a statewide nursing labour force survey each year in NSW, it is not possible to determine the specific place of work of midwives because of the nature of the role and its interface with additional nursing roles, particularly in rural and remote areas. There is a need to further investigate the midwifery workforce in NSW to determine workforce planning issues and priorities for the next five years. Strategies identified in *The NSW Framework for Maternity Services* focus on this task and on providing flexible work practices, developing new skills associated with new models of care and accessing refresher courses and ongoing educational opportunities that may assist in retaining certified midwives in maternity services.

- **Student Midwives**

The *NSW Midwifery Taskforce Report Final Report* ⁴ recommended a continued embargo on student midwifery numbers at the 1993 level of 313 per year. Since then, concerns about student midwifery workforce numbers have continued to be raised, most recently in the *NSW Health Workforce Planning Study For Maternity Service Nurses, Adult Critical and Intensive Care and Operating Room Nurses* ⁷ and *The Obstetric and Gynaecology Workforce In Australia*.⁸

In September 1998, as part of the work of the Maternity Services Advisory Committee, each Area Health Service and university was surveyed by the NSW Health Department to establish current and projected numbers of student midwives. This survey highlighted a current shortfall of student midwives and that a decline in numbers can be expected unless strategies are developed to reverse the trend. The Nursing Branch of the NSW Department of Health is exploring the results of the survey. In conjunction with Area Health Services and universities, it will be developing a range of strategies to address the numbers and distribution of student midwives across the state.

- **Industrial issues**

The continued development of new service models, particularly those involving midwives in providing continuity of care, poses particular challenges. To date, negotiations between Area Health Services and the NSW Nurses Association have resulted in the initiation of a small number of pilot roster projects.

There is a need for progression of industrial arrangements for midwives involved in the new models of care as these services expand and evolve. This is critical to both the development of the models and the ongoing professional growth of midwives.

- **Professional indemnity issues**

NSW Health currently has a policy that recommends cover of \$5 million professional indemnity for visiting midwives. This is subject to ongoing review in the light of additional cover becoming available.

Models of Care and Collaborative Practice

The development of a collaborative and consultative framework and the achievement of increased continuity of care and improved access to midwifery services continue to be a major challenge within NSW maternity health services. With an increasing focus on evidence-based practice, the potential of innovative models of maternity care that incorporate these features cannot be underestimated. Furthermore, there needs to be sufficient scope for women's views and choices to be taken into account and for decisions to be made based on women's informed choice.

There is a growing recognition of the desirability of offering a range of service options and models of practice in maternity services. Typically, such services are characterised by their distinctive adaptation to a local geographic area and the clinical needs and expressed preferences of the local population. They also demonstrate an appropriate balance between community- and hospital-based care and the incorporation of shared care arrangements and private practice. Within the context of availability of suitably qualified health care professionals and access to a tiered network of primary, secondary and tertiary health services (not all of which are necessarily provided locally), these services also need to reflect current evidence and best practice.

The Shearman Report ¹ supported the view that Area Health Services should adopt a program approach to providing maternity services based on evaluating local community needs and identifying an appropriate mix of hospital- and community-based antenatal, childbirth and postnatal care services, including comprehensive parenting education services. The National Health and Medical Research Council report, *Options for Effective Care in Childbirth*,³ further supports the need for health services to develop a range of options and different models of care that reflect local community need and increase the utilisation of midwives and general practitioners.

In addition, the Maternity Services Advisory Committee reviewed a further two reports pertaining to maternity services. The WHO publication, *Care in Normal Birth: A Practical Guide*,⁹ is the result of a group of international experts collaborating to determine what they consider to be appropriate care in normal birth. In late 1998, NSW Department of Health released a report entitled *Evaluation of New South Wales Alternative Birthing Services Program, Second Phase 1993/94–1996/97*,⁵ which contains recommendations that further assist efforts to improve maternity services and health outcomes for Aboriginal and Torres Strait Islander women and their families. Also, as previously discussed, the *Guidelines and Service Models for Ethnic Obstetric Liaison Services in NSW —A Summary Report*⁶ provides an important adjunct and appropriate framework for developing maternity services for NESB women.

The committee endorses these recent reports and recommends them as a blueprint for the ongoing development of maternity policy, practices and philosophy and of new models of maternity care.

Innovative models of maternity care are being piloted and implemented in some Area Health Services in response to changing populations, service needs and available resources; however, it is not possible to determine the exact scope of these innovations. Information obtained from the *NSW Maternity Services Status Reports* illustrates that development and implementation of new models of care such as those recommended is not extensive, particularly in rural and remote areas of NSW. *The NSW Framework for Maternity Services* provides a systematic approach for reshaping maternity services over the next five years. The willingness of all stakeholders within health services to work collaboratively with

consumers and members of the community is paramount in ensuring that services are developed in a way that is both efficient and appropriate, as well as safe and effective.

Rural Maternity Services

Women in rural and remote areas of NSW, especially those outside regional centres and those who experience difficulties accessing maternity services because of distance or lack of a full range of services, face specific challenges. Difficulties in recruiting health workers to rural areas further limits access to services. For a population with differences in linguistic and cultural backgrounds, the limited availability of Aboriginal and Torres Strait Islander health workers, interpreter services and bilingual health workers further contributes to the disadvantage that these women and families experience.

NSW Health recognises the need to develop a strategic approach to establishing, developing and maintaining rural maternity services. In this regard, the document, *Caring for Health: the NSW Government's Vision for Rural Health*,¹⁰ proposes that 'innovative options for childbirth' should be made available to rural women, and that 'rural health workers should receive training in the assessment and management of postnatal depression'.

Since 1996, NSW Health Department funding initiatives have enabled the development of several rural health workforce strategies. These include the Pilot Locum Service to provide leave relief for rural obstetricians and gynaecologists, recruitment of rural GPs, and support for expansion of the number of medical speciality and refresher training positions in rural areas. NSW Health has also developed several initiatives to support the maintenance and development of a skilled midwifery and nursing workforce in rural NSW. These include funding for two rural/remote professorial chairs, a Rural/Remote Nursing Scholarship Fund, the Maternity Emergencies Survival Package for Registered Nurses (non-midwives), midwifery refresher courses and the development of careers marketing and recruitment materials.

To address issues relating to providing quality, safe and accessible services to women and babies in rural and remote areas, a range of community and practitioner issues require consideration. Specific matters warranting attention include transport services, cultural sensitivity of staff, the role and delineation of small units with low annual birth rates and the development of innovative options and models of care that move services closer to where women live. Further, the integration of maternity services, in particular those provided by midwives, into existing community/primary health care services such as Aboriginal Medical Services and general practitioner models of care, will be an ongoing challenge for NSW Health. *The NSW Framework for Maternity Services* identifies several strategies to improve the range, standard and availability of services as well as to increase equity of access for women seeking maternity services in rural and remote NSW.

Professional Development/Continuing Education

Issues relating to professional development/continuing education of the maternity workforce are multifaceted and influenced by such factors as funding availability, staffing levels and the availability of relief staff. The geographic location, accessibility and cost of programs, and the relevance of available courses to current practice and changing models of service are all factors that affect staff access to ongoing education and learning new skills.

Continuing education and professional development programs need to address both the specific clinical training needs and the broader career interests of the different professional groups that provide maternity care. *The NSW Framework for Maternity Services* includes strategies directed towards ensuring:

- access to regular in-service education programs for all personnel providing maternity care, including staff release to participate in hospital-exchange programs; short courses addressing new and emerging service-delivery issues; and regular hospital or community based in-service or clinical review meetings
- hospital-based accreditation with regular review for all practitioners providing maternity care, including independent and visiting midwives and medical practitioners
- availability of continuing education programs and courses of advanced training relevant to general practitioners who provide shared antenatal and postnatal care
- review of the content of undergraduate, postgraduate and continuing education programs for doctors and midwives to strengthen the development of communication and clinical skills required to provide culturally appropriate and sensitive maternity care, including practice in models of continuity of care.

The Committee considered the issues of ongoing competence and recency of practice of maternity care providers and identified gaps in the ability of Area Health Services to ensure minimum levels for safe practice. While it is recognised that both medical and midwifery colleges have or are developing credentialing systems for their members, it is important that health services also fulfil their role in this regard. *The NSW Framework for Maternity Services* provides a number of strategies that will assist in addressing the maintenance of skills to ensure safe and effective care by all staff. The Committee was informed of the midwifery supervision model in the United Kingdom¹¹ and recognised it as a good model that provides both employed and independent midwives with support, mentorship and guidance in clinical practice while fulfilling an important role in protecting the public.

Professional Organisations

In November 1995, the Royal Australian College of Obstetricians and Gynaecologists (RACOG) approved that advanced trainees could be trained in posts in major rural centres. The spirit of this resolution is to encourage trainees to acquire experience in country centres. This initiative may help to alleviate the increasing shortage of specialist obstetricians in country centres. It is recognised that more needs to be done to relieve the difficulties of providing services in rural areas. General practitioners wishing to provide a full obstetric service require the RANZCOG Diploma in Obstetrics, and this should continue to be the recognised qualification. The Joint Consultative Committee of RACOG (in late 1998 merged with New Zealand College of Obstetricians and Gynaecologists to form RANZCOG) and the Royal Australian College of General Practitioners (RACGP) have recently approved a three-level training system for general practitioner obstetricians.

The New South Wales Midwives Association, Inc., a branch of the Australian College of Midwives. Inc., (ACMI) conducts refresher programs for qualified midwives who want to re-enter the workforce, as well as a range of educational activities including clinical skills workshops, seminars and conferences in rural and metropolitan locations. In consultation with and with funding from the NSW Health Department, it has also developed the *Maternity Emergency Guidelines for Registered Nurses*¹² for use in health services with limited or no maternity service options. The Association is also invited to participate on a number of NSW Health Department committees and meets regularly with the Chief Nursing Officer to keep her informed on midwifery issues.

The NSW College of Nursing conducts assessment of overseas-qualified midwives so they may gain recognition of their midwifery qualifications and authorisation to practise midwifery in NSW. A range of refresher and continuing education courses are open to midwives through the College.

Consumer and Non-Government Organisations

The value of consumer participation in developing and evaluating maternity services cannot be underestimated.

Various New South Wales consumer and non-government organisations undertake support, information and educational activities that supplement public- and private-sector maternity services. These activities are usually undertaken voluntarily and include:

- childbirth information
- breastfeeding advice

- promotion of alternatives to hospital maternity care
- support for families who experience multiple birth, diagnosis of fetal abnormality, miscarriage, stillbirth, neonatal and infant death, and birth of a child with a disability.

Some consumer and non-government organisations that provide information for women and their partners are the Nursing Mothers Association of Australia, the Australian Multiple Birth Association, and the Stillbirth and Neonatal Death Support (SANDS) group. Several other consumer and non-government organisations provide information for health professionals about families with special needs.

Increasingly, consumer organisations are receiving requests from educational institutions and continuing professional education programs—such as Charles Sturt University (Nursing), Sydney University (medical) and the NSW College of Nursing (midwifery)—to share their particular expertise with health professionals at undergraduate and post-graduate levels.

Consumers throughout NSW actively participate in local and state maternity services advisory committees, and their role and contribution in this regard can be expected to grow considerably with the expansion of this initiative. Many consumers willingly participate in research activities undertaken to assess quality of care or to evaluate clinical effectiveness of interventions. Consumers have a vital role in enhancing communication and feedback and thereby enabling services to set priorities in areas that need improvement.

A Vision and Philosophy statement for NSW Maternity Services

Over the past few years, health service executives, planners, policy analysts, managers, providers and consumers have engaged in constructive and increasingly informed discussions and debates about the provision of maternity services in NSW. The deliberations of the Maternity Services Advisory Committee have enabled further informed and in-depth discussion. A general consensus has emerged about the need for Area Health Services to implement integrated and collaborative models of maternity care that:

- are safe, accessible and effective
- are culturally sensitive and responsive to the needs of individual consumers
- enhance continuity of care across antenatal, delivery and postnatal services
- promote consumer consultation and participation in planning and evaluating maternity services

- achieve an appropriate balance between community-based and hospital-based care
- have available the necessary levels of intervention and technology, in accordance with the service's/facility's delineated role
- are evidence-based
- are supported by an appropriate number and mix of health care professionals with the necessary knowledge, skills and experience
- enhance implementation of shared-care models between key service providers.

The committee endorsed the direction and principles for maternity care as outlined in the state and national reports discussed previously. A philosophy that reflects the intent and vision of these reports as well as the current research evidence was developed to incorporate the seven goals of the strategic plan, namely:

NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.

Continuity of care and consistent information are essential to the provision of care that is culturally sensitive and appropriate.

Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.

Conclusion

This report has identified and explored the current issues in maternity services in NSW and provides strategic objectives for developing and implementing future services. To move forward in these strategic directions, a number of issues warrant focused attention and concerted action on the part of health professionals, Area Health Services and the NSW Health Department.

The five-year goals, objectives and strategies for NSW Maternity Services set out in the following section provide a framework and systematic approach to assist this process.

The need for collaboration and consultation between service providers and consumers to better determine needs and priorities is paramount. This collaboration and consultation is not only to ensure that services are safe, efficient and effective, but also that they are respectful, personalised and rewarding for both consumers and providers of maternity care.

DOCUMENTS FROM THE MATERNITY SERVICES FRAMEWORK NOT INCLUDED IN THE DOCTORATE SUBMISSION DUE TO THEIR SIZE:

FIVE YEAR GOALS, OBJECTIVES AND STRATEGIES FOR NSW MATERNITY SERVICES

APPENDIX A: Form used for NSW Health Status Report – Maternity Services

APPENDIX B: NSW Maternity Services Status Reports

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GLOSSARY

Aboriginal health	In the context of the health of Aboriginal people, the definition of health is expanded to include the total wellbeing of a whole community and not just individuals. 'Aboriginal health means not just the physical wellbeing of an individual but also the socio-economic, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community'. ¹⁵
ABSP	Alternative Birthing Services Program, funded by the Commonwealth Department of Health and Family Services and the NSW Department of Health
ACHS	Australian Council of Healthcare Standards
ACMI	Australian College of Midwives, Inc.
AHS	Area Health Service
AMWAC	Australian Medical Workforce Advisory Committee
Birth plan	A plan, developed between a pregnant woman and a midwife, of the woman's preferences for her care and that of her unborn child during labour and childbirth
Childbirth Education Services	The provision of a structured program of education/information about pregnancy, labour, birth and early parenting to women and their partners
CIAP	Clinical Information Access Project
Consumers	Users of maternity services, e.g. the pregnant woman and her family
Continuity of Care	Care which enables child-bearing women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period. Continuity of care can be provided in different ways and to varying degrees. Very few models actually provide complete continuity of care throughout all stages ¹⁶
Early discharge	Discharge from a maternity unit within 48 hours of giving birth
EOLO	<i>Ethnic Obstetric Liaison Officer</i>
EQulP	<i>Evaluation and Quality Improvement Program of the ACHS</i>
FTE	<i>Full-time equivalent</i>
GP	<i>General Practitioner</i>
Independent midwife	A person authorised to practise midwifery in NSW who works privately and independently of a hospital or health service. Independent midwives may be accredited with the Australian College of Midwives, Inc.
Midwifery models of care	Models of maternity services in which midwives are the primary caregivers. These services may include midwife

clinics, domiciliary midwifery, team midwifery, independent midwifery and birth centres. These models of maternity care are based on a primary health care philosophy and principles

<i>MSLC</i>	<i>Maternity Services Liaison Committee</i>
<i>NESB</i>	<i>Non-English speaking background</i>
<i>NHMRC</i>	<i>National Health and Medical Research Council</i>
Normal birth	Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. This infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition ⁹
NSW Health	All employees of the NSW public health system
NSW Health Department	Central administrative office of NSW Health, based at North Sydney
PND	Postnatal depression
Primary health care	<p>As defined by the World Health Organisation, 'essential health care made universally acceptable to individuals and families in the community by means acceptable to them, through their participation and at a cost that the community can afford. It forms an integral part of both the country's health system of which it is the nucleus and of the overall social and economic development of the community'¹⁷</p> <p>Primary health care is defined and understood as:</p> <ul style="list-style-type: none"> a philosophical approach to the development and delivery of health care and health care systems. It is based on a broad concept of health that is characterised by social justice, equality and self-responsibility for one's health maintenance a framework for the development of services that are appropriate and relevant to the needs of local communities and are affordable, integrated and characterised by inter-sectorial collaboration. The participation of communities and individuals in the planning, organisation, operation and control of their health services is a key feature of the primary health care approach to service development a level of care, which is the first point of contact with the health care system a set of activities that address the main health problems identified in a country providing promotive, preventative, curative and rehabilitative services. It may include health education, nutrition promotion, clean water supplies, immunisation, family planning, major infectious disease control, etc.^{4,17}
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Shared care	In the context of this report, the provision of care that is shared between general practitioners, obstetricians, midwives and/or Aboriginal or Torres Strait Islander health workers
Team midwifery	A model of maternity care provided by a small team of midwives in collaboration with an obstetrician that focuses on continuity of care through all stages of pregnancy, labour, birth and early parenting
<i>TQI</i>	<i>Total quality improvement</i>
<i>Visiting Midwife</i>	<i>An independent midwife accredited by agreement with a particular health service to provide care to her own clients within the hospital or health service</i>
<i>VMO</i>	<i>Visiting medical officer</i>
<i>WHO</i>	<i>World Health Organisation</i>

**APPENDIX E: SUBMISSION TO THE NSW HEALTH DEPARTMENT FOR
THE REVIEW OF THE NURSES ACT 1991**

NEW SOUTH WALES MIDWIVES



ASSOCIATION (INCORPORATED)

**REVIEW OF THE
NURSES ACT 1991
SUBMISSION TO
NSW HEALTH DEPARTMENT

OCTOBER 1999**

NEW SOUTH WALES MIDWIVES ASSOCIATION (INCORPORATED)

REG. NO.Y11716-42 A BRANCH OF AUSTRALIAN COLLEGE OF MIDWIVES INCORPORATED

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ACKNOWLEDGEMENT

The Legislation Sub-Committee of the *NSW Midwives Association (Inc.)* have prepared this submission on behalf of the Executive Committee and membership of the association.

Members of the committee at the time of writing this submission were:

Pat Brodie (Convenor)

Hannah Dahlen

Carolyn Hastie

Ann Grieve

Sally Tracy

We wish to acknowledge the work of former members of the Legislation Sub-Committee for their endeavours over many years. Their commitment to the pursuit of regulatory structures more in keeping with the practice of the midwifery profession in NSW has been an inspiration to those that followed them.

A REVIEW OF THE NURSES ACT 1991: SUBMISSION TO NSW HEALTH DEPARTMENT

DISCUSSION POINT 1

Does the above discussion adequately set out the scope of the market for nursing services? Are there occupational groupings that are affected by the provisions of the Nurses Act, which have not been considered?

The discussion in Part Two does not adequately set out the scope of the market for *midwifery* services. Direct entry midwives who come to NSW and seek to be registered are currently inappropriately required to register as a nurse, even they do not have approved qualifications. This is an anomaly in the Act and must be corrected. This is misleading, inaccurate and misrepresents the particular skills and abilities of midwives. This has implications for employers and is not protecting the public.

The practice of midwifery or nursing is not defined in the Act. If they were to be defined we would recommend that the definitions be flexible and not restrictive of the broad 'scope' of midwifery and nursing practice. This will expand the scope of the market for midwifery services by allowing for midwives who are *not* nurses to be registered in NSW.

There needs to be an extension of the amendment to the Act that will regulate 'nurse practitioners' to include the accreditation of 'midwife practitioners'.

DISCUSSION POINT 2

Should lists A & B of the Register and/or Roll be merged?

Submissions arguing that separate lists should be maintained on health and safety grounds should specify the benefit to the public health and safety of maintaining separate lists.

We recommend separate registers for midwives and nurses. The skills and practices of each profession are distinct and different. The public has a right to this information and a separate register is legal recognition of the difference in the professions. A separate register protects the public. It is not appropriate to have a nurse provide midwifery care. Having a separate register for the professions ensures that there is no confusion regarding the role of nurse and midwife. Two registers would ensure that those that had both professional qualifications were

recognised as having completed both educational pathways. Some nurses may also need to work as midwives and thus would require being on two registers. Given the current workforce shortages it is important that requirements for both lists should be sufficiently flexible not to reduce our potential pool of registered midwives and nurses. The excessive medicalisation of childbirth has diminished women's control over their reproductive experience and lead to unacceptably high incidences of intervention and operative births. This is a public health issue of great importance. Research has demonstrated clearly that women want more humanised care, less intervention and more control (Biro & Lumley 1991; Brown & Lumley 1994). Studies have shown that midwifery care provides the sort of care that women want and that also improves health outcomes (Flint & Poulengeris 1989; Harvey et al 1996; Kenny et al 1994; McCourt & Page 1996; Rowley et al 1995). Midwifery education is changing to accommodate a 'woman centred' focus to maternity care provision. New models of midwifery care are being developed, models which demand a primary health care approach and greater responsibility and autonomy for midwives. The changing role of midwives and the rapidly expanding professionalism of midwifery require a legal recognition of the role and profession of midwifery (Leap 1999). A separate register for midwives and changing the name of the Act to the Nurse's and Midwives' Act is essential so that legislation keeps pace with reality of contemporary maternity care.

DISCUSSION POINT 3

What are the objects of the Nurses Act and do they remain valid? Comments on the desirability of including in the Nurses Act a statement of its objectives are invited. Submissions in favour of this proposition, which canvass the content of any objects clause, would be particularly welcome.

The purpose of the Act is to protect the public from unsafe practice and to provide a forum for consumers to bring complaints regarding unsatisfactory care to the attention of the Board.

The board's objectives are to provide:

- mechanisms to protect the public against incompetent practice, unsatisfactory professional conduct and the recognition of level of impairments amongst nurses and midwives

- mechanisms to ensure the provision of advice to nurses and midwives about matters relating to professional competence and conduct and identification of levels of impairment
- mechanisms to remove from the register those nurses and midwives whose practice, conduct or level of impairment is found to be unsatisfactory.

The professional bodies for midwives and nurses provide:

- mechanisms for the accreditation of midwives and nurses
- mechanisms to ensure that professional standards are maintained at an acceptable level and,
- a framework for educational programs.

Any revision of the Objectives should add the words 'and midwife/midwifery' to all references of 'nurse/nursing'.

DISCUSSION POINT 4

What evidence is there to support the need for regulation of practitioners providing nursing services? What is the impact of the current restrictions on competition?

Midwifery and nursing should both be regulated for the protection of the public and maintenance of public trust and confidence with the professions. We believe that it is time for midwifery to be identified separately within the Act in recognition of the unique contribution that midwives make to optimising maternity health outcomes. Wherever there is a strong and autonomous midwifery profession, there is a powerful advocacy for women and women's choices in childbearing issues (Guilliland & Pairman 1995; Katz-Rothman 1991). Countries such as New Zealand, Sweden, Holland and the UK all have statutory regulation of midwifery and enjoy improved maternal and neonatal outcomes and are experiencing a proliferation of midwifery models of care (Department of Health 1993). These phenomena are directly related. Therefore to protect the public, a strong, autonomous regulated midwifery profession is necessary.

DISCUSSION POINT 5

What is the most appropriate type of regulation for the nursing profession in NSW? Submissions should address the costs and benefits of any regulatory model proposed.

DISCUSSION POINT 6

Should there continue to be regulation of midwifery? If so, what is the most appropriate form of regulation? If it is considered that regulation should be by title and core practices, what core practices should be restricted? If it is considered that regulation should be by title and whole of practice, what should the definition for midwifery be? Should the Act continue to provide exemptions for certain categories of persons from the restrictions on the practice of midwifery? If so, which categories of people should be exempted and what should those exemptions be? Submissions arguing in favour of restrictions, whether they be on title or on both title and area of practice, should provide evidence of risks to the public and that restrictions are therefore necessary in the interests of public health and safety.

The most appropriate type of regulation at this time, for the midwifery profession, is self-regulation through a Midwives and Nurses Act (Alphabetically this is just). Midwifery has long been recognised as a discipline distinct from nursing in other countries. The practice of midwifery was regulated in the UK some seventeen years before the registration of nurses, as a result of the concern of medical practitioners about unqualified birth attendants. The current UK registration statute is titled the *Nurses, Midwives & Health Visitors Act*, which recognises the different disciplines. This legislation was recently reviewed and the report is recommended to NSW Health in it's deliberations (UK Health Departments & JM Consultancy Ltd 1998). It is significant that this major review of the Act in the UK highlighted the need to "ensure that the public protection afforded by the Act is effective while not stifling developments in health care' (p6). Like no other time in Australia there is an extensive amount of public health reform, restructuring of services and developments of new models of maternity care that are emphasising the unique benefits and potential of midwives as health care practitioners (NHMRC 1996 & 1998; NSW Health Department 1989 & 1999).

Joint regulation of nursing and midwifery with full participation from both, gives due recognition to the profession of midwifery in Australia and will bring us into line with

other Western countries. Recent changes in legislation in New Zealand have seen midwifery recognised as an autonomous profession, distinct from nursing.

The two professions of nursing and midwifery differ in their practice and education, but they share common values and principles that mean that they can effectively come together in the public interest for the purpose of statutory regulation. We should work together on the principles, standards and mechanisms to regulate our education, practice and professional conduct whilst retaining our distinct areas of practice, education and professional bodies. Together we can respect and learn much from each other.

Such an alliance will ensure 'profession specific' issues are addressed by the relevant group along with the involvement of all key stakeholders. Policy and strategic directions for both professions would be developed jointly, to the benefit of both, whilst ensuring that neither profession is dominated or dictated to by the other. To reduce excessive infrastructure costs associated with two separate regulatory bodies, a change in the title of the Act to the '*Nurses and Midwives Act*' would appear the most appropriate amendment to the legislation.

We believe that regulation should be by title and scope of practice and the scope of midwifery practice encompass the following:

Midwife means 'with woman'. A midwife is a specialist who has been educated to provide midwifery care to childbearing women (and families). This includes pre-pregnancy counselling, antenatal, labour and postnatal care, referring to other health professionals as appropriate. The scope of practice of a midwife should be aligned with the Australian College of Midwives (ACMI) competencies of the midwife (1998).

Protection of title is an important element in protecting the public and this should apply to midwifery. This would make it unlawful for anyone other than registered midwives to hold themselves out to be a registered midwife. This is most important in contributing to the public's perception of the distinction between the professions of nursing and midwifery and enhances their 'informed choice' around maternity care. As stated in the *NSW Health Issues Paper* specifically prepared to assist in this review: "The objective of title restriction is to protect the public by ensuring that consumers are able to identify qualified persons" (p26). The public need to be aware if they are receiving care from a midwife, or a nurse or a doctor. It is noted however

that protection of title is of little importance unless the public are educated to understand the significance of the title and are able to understand the Act.

We recognise that within the current workforce shortage crisis there is considerable difficulty in restricting the practice of midwifery to midwives only. In addition, we recognise that certain aspects of the care provided to women includes a range of skills and tasks that can be performed by others who are trained to do so in their chosen discipline. Examples of these skills include: recording of blood pressure, assisting a woman to breast feed her baby, recording of medical history etc. What is unique to midwifery however and what identifies it as separate from nursing and medicine is the 'continuity' of skills and care across a spectrum of time in a woman's life. There is considerable evidence to support midwifery continuity of care as the cornerstone of 'best practice' in maternity care (Brown & Lumley 1998; Hodnett 1996; Oakley et al 1996; Page 1995; Rowley et al 1995; Tew et al 1991; Tucker et al 1996; Turnbull et al 1996). The 'continuum' of care and practice, which is unique to midwifery, involves antenatal care, all of labour and birth care and the post partum period. Central to this 'continuum' of care is 'the relationship' that develops between a woman and her midwife that has an impact on health outcomes and morbidity (WHO 1996).

Continuity of care and social support during pregnancy and childbirth are critical factors in improving women's maternity health care outcomes and they are linked to long term health gain (Oakley et al 1996). Within the concept of continuity of carer, this relationship is different from any other relationship that involves health care workers.

"Having a baby can be seen as a rite of passage. In many situations throughout the world, there is 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. This includes the physical, intellectual, social and spiritual challenges and ramifications of childbirth. The midwife maintains the 'midwifery overview' ensuring that all these interwoven elements of the woman's life are kept in relief, whatever the events that unfold. The midwife works with the woman and her community, collaborating with other health professionals if necessary, to ensure that everything is done to ensure a safe and supported transition to new motherhood, taking into consideration the woman's individual circumstances and wishes" (Leap 1999).

We recommend that only suitably qualified and registered midwives have overall *responsibility* for midwifery care and as such midwifery practice should only be performed by non-midwives *under the supervision of registered midwives who are in current practice*. Maternity care provided to women by medical officers is not midwifery and as such does not fall into this area of regulation. The newly named 'Nurses & Midwives Board' must involve the midwifery profession in articulating the exact nature of *supervision* to determine an appropriately clear articulation and meaning of this term. This is critical to the review of the Act in order to protect the public from unsafe care, ensure employers are able to provide appropriate personnel and also to ensure that midwives maintain responsibility for midwifery care and practice.

There is a long history of midwifery being subsumed into nursing in this country, with disadvantages to both midwifery and the public. Midwifery has not had a strong voice in the corporate health-planning sector. Senior nurses have been required to represent both nursing and midwifery with a natural tendency towards nursing being dominant. This has meant that despite all the evidence linking improved maternal and infant outcomes with strong autonomous midwifery practice, such practices have not flourished. There are numerous studies and government reports that recognise the necessity for midwifery models of care to reduce associated costs associated with high levels of intervention and morbidity for women in childbearing. (DOH Victoria 1990)

The recommendations for and recognition of a necessary reorganisation of the way that maternity services are provided will mean a restructuring of the midwifery profession, including a new and fresh approach to educating midwives (Baldwin 1999; Page 1993). Many nurses have been educated as midwives and have never practised midwifery. This is inefficient and wasteful of resources. Direct entry midwifery education is recognised internationally as the most appropriate way of preparing midwives to work in the new models of care. Tertiary educational organisations across Australia, in recognition of the shift to more effective models of midwifery care, are developing innovative collaborative approaches to midwifery education that include a three year Bachelor of Midwifery (Direct entry midwifery) (Leap 1999). It currently takes five years (minimum) to educate a midwife via the nursing route. It is counter productive and a waste of resources to insist that all midwives must be nurses.

If NSW is to attract more midwives to redress the shortage of midwives, it will need to recognise that other countries, for example UK and New Zealand, have instituted direct entry midwifery programs through which it is possible to become a midwife without having studied nursing first. Recruitment to such programs appears to be very successful, and such a strategy might address some of the midwifery recruitment problems currently faced by NSW.

DISCUSSION POINT 8

How should competency be assessed? Is the current range of qualifications recognised by the Board appropriate? Should the process used by the Board to accredit educational programs be changed and if so, in what manner?

Is there any evidence that competent people are prevented, by the Board's accreditation criteria, from practising nursing?

Currently there is a huge discrepancy and disparity between midwifery educational programs across the country. There needs to be extensive national review and consultation to determine what is an acceptable national standard for midwifery education. The attainment of internationally recognised standards would enable Australian midwives to work in other countries without having to complete further studies or clinical experience.

The NSWMA (ACMI) should be given a greater role in the accreditation of midwifery educational programs and we recommend adoption of the Australian College of Midwives (ACMI) competencies of the midwife (1998).

One of the emerging concerns within current maternity care provision is that of Indigenous women's maternity care. With particular reference to rural and remote areas, we are aware of birthing practices and services on the homelands provided by traditional birth attendants (TBAs). It is possible that these people may be competent and, under the act, are practising illegally. Regulation of the practice of registered midwives does not restrict the number or practices of unregulated health care workers who may be practising certain aspects of midwifery. Given the poor health outcomes for Indigenous people (AIHW 1998; Day et al 1999), and recommendations for models of care that promote the involvement of Aboriginal Health Workers (National Aboriginal Health Strategy 1997), this issue needs special consideration. We seek the opportunity to work closely with the new Board to develop strategies to address this important challenge.

DISCUSSION POINT 9

What additional accreditation requirements, if any, should be introduced?

Should the Board be able to refuse to accredit a person, otherwise entitled to accreditation, in certain circumstances? If so, what matters should be considered in making that decision? Is there merit in including a recency of practice requirement in the legislation? If so, what length of time should be specified and how should practice be defined?

DISCUSSION POINT 10

Does the Act provide the Board with sufficient flexibility in granting registration, enrolment, and approval to practise midwifery? Submissions are sought on the types of accreditation the Board should be able to grant, and the circumstances in which they should be granted.

DISCUSSION POINT 14

What strategies should be adopted, if any, to ensure that nurses remain competent to practise? Is there any evidence that nurses are failing to maintain standards at an appropriate level and that consumers are thereby exposed to harm? Should the Board have the power to refuse an application for restoration and if so, on what grounds?

The advantages and disadvantages of any strategies advocated should be discussed.

The issue of recency of practice is a complex and important issue. The current shortage of midwives necessitates the preservation of every midwife available. This does not address issues of quality or competence. There is an argument that as professionals in their own right, midwives and nurses should be self-regulating. There are multiple considerations that will require exploration through a collaborative approach with key stakeholders. In the long term we believe that a recency of practice requirement in the legislation is important and that this should reflect a national standard. A national standard will allow for the mutual recognition of accreditation from other states and territories. With regard to temporary and provisional registration, this can be linked to the recency of practice issue. For example, in one state, midwives may continue to be registered annually, but require a current 'authority to practice' if wishing to provide direct clinical care. In another, they must sign that they have maintained competence and have determined for themselves that they are safe to practice. Such an arrangement may address some

of the concerns of dedicated midwives working in fields other than direct clinical care. It would however raise the complexity of issues surrounding refresher and re entry programs including who provides them, as well as costs, content, standards and quality.

We acknowledge the paucity of evidence to demonstrate a concern regarding standards of, or complaints about midwifery care, but do not believe that this is necessarily an indicator of high standards of professional competence. The NSWMA has considerable anecdotal evidence that highlights concerns with fitness to practice amongst some midwives and also 'fitness' to be in the role of supervising non-midwives, especially in rural and remote areas and those areas with midwifery staff shortages. Whilst self-regulation is the ideal for any profession, there is a diversity of opinions that need to be exchanged and explored so that there is an understanding of what constitutes a reasonable level of competency amongst midwives.

The Australian College of Midwives has already gone some way toward establishing some means of measuring the individual's commitment to ongoing education with the development of the Professional Development Credit Point (PDCP) system. The PDCP system enables midwives to maintain a record of continuing professional education undertaken, with each educational opportunity being given a numerical value according to its content and the credentials of the presenters. It can be reasonably expected that the average midwife will accumulate 40 points in any one year period, although the potential for much more is there. This system, together with the ACMI Competencies, Code of Practice and Code of Ethics could form a basis for discussion of the need (or otherwise) for compulsory continuing education for midwives. We therefore recommend that the Nurses & Midwives Board in partnership with NSWMA (the state branch of ACMI), explore these as well as the international systems and mechanisms for maintenance of midwifery standards to determine what constitutes appropriate professional activity the best way forward regarding policy on this crucial issue.

DISCUSSION POINT 11

Should the Nurses Act incorporate the mutual recognition of accreditation from other States and Territories?

Once the national standard for recency of practice and educational standards are set, the Nurses and Midwives Act should incorporate the mutual recognition principle of accreditation from other States and Territories. The adoption of mutual

recognition principles within accreditation procedures would allow for direct entry midwives from other countries to register in NSW.

DISCUSSION POINT 12

Should the operation of s 25 of the Nurses Act be extended to allow interstate registered nurses to practise in NSW without registration for periods in excess of 24 hours? Should a similar provision be inserted in the Act to allow enrolled nurses to practise in NSW without accreditation for a limited period of time?

With a mutual recognition principle of accreditation in place, we think that section 25 becomes irrelevant.

We believe that it is appropriate that such a provision should also apply to enrolled nurses.

DISCUSSION POINT 13

Should nursing students be accredited by the Board? If so, should both students studying to be registered nurses and students studying to be enrolled nurses be required to apply? Submissions advocating student accreditation should provide evidence of the public harm that will be prevented and an analysis of the costs and benefits involved.

We do not think that students undertaking the Bachelor of Midwifery programs in the future (DEM) require accreditation by the Board. The educational institutions must ensure adequate supervision of students and have the responsibility to provide processes to address any concerns they may have with a student in regards to public safety and the welfare of the student. The educational institutions also have a responsibility to ensure that the student is fit to practice under supervision.

DISCUSSION POINT 15

Should the Nurses Act contain some type of mechanism to review a decision by the HCCC not to prosecute a complaint? Submissions advocating such a mechanism should provide details and explain how such a mechanism will not compromise the HCCC's legitimate prosecutorial discretion.

The Nurses & Midwives Board and the HCCC should maintain the right to investigate complaints independently of each other in the interests of public safety and maintenance of professional standards. There should however be a degree of cross-referencing between the two bodies and there should be a requirement that all

complaints about midwives and nurses received by the HCCC are also referred to the Board.

DISCUSSION POINT 17

Should nurses be under a positive obligation to notify the Board if an offence is proven against them? Should nurses be under a positive obligation to notify the Board if they are charged with an offence of a serious nature, which relates to conduct occurring in the course of practice? Should the Nurses Act include a provision requiring the courts to notify the Board when a nurse is convicted of an offence?

In order to protect the public, midwives and nurses as well as the courts should be under an obligation to notify the Board if an offence is proven against a midwife or nurse, if the circumstances suggests that they are unfit to fulfil their role safely.

DISCUSSION POINT 18

Should breach of the code of conduct itself be grounds for complaint about a nurse? The Department invites comments on the desirability of amending the manner in which codes of professional conduct are adopted to lessen their potential impact on competition.

The purposes of the Code of Conduct are to inform the public and profession of the minimum standards for professional conduct and secondly, to provide a basis for decisions regarding standards of professional conduct.

Breach of the Code is indeed grounds for complaint. A non-adversarial form of investigation with peers needs to be undertaken to establish that the breach has occurred. Following this, some form of educational/supervision system needs to be established to enable the nurse/midwife to correct practices/behaviours that led to the breach of the code.

DISCUSSION POINT 19

Should chairs of Professional Standards Committees be required to have any particular qualifications or experience?

We believe that the chair of the Professional Standards Committees must be legally qualified and have extensive understanding of the issues under review.

DISCUSSION POINT 20

Comments on the desirability of creating a more structured mechanism for appointing members of the panel of laypersons to sit on PSCs and the Nurses Tribunal are invited.

Consumer membership on the Board is essential. Submissions of interest should be called for when considering consumer representation. The person(s) ought to be required to submit an application, resume and a statement of interest and also attend an interview with members of the Board and some of the key stakeholders, for example the Chief Nurse, Chief Midwife, and or representatives from professional bodies, to determine their suitability and reason for interest.

DISCUSSION POINT 21

Comments are invited on the composition of PSCs and the Nurses Tribunal. Should members of the Board be precluded from sitting on PSC s and Tribunals.

Yes, Board members should be excluded from the PSCs. Given that it is often a member of the Board that refers the matter to the Professional Standards Committees and Tribunals, members of the Board should be precluded from sitting on Professional Standards Committees and tribunals. It could lead to a conflict of interest or a potentially biased situation.

Clearly, it is essential that appropriate numbers of midwives sit on PSCs involving midwifery and nurses on those involving nursing, although these do not need to be mutually exclusive of each other. The Board will determine the exact composition and structure of the committee, however the development of some agreed principles around collaboration and recognition of boundaries of professional practice would seem beneficial. This should include a principle that neither profession can be out voted by the other on matters, which are specific to their profession.

DISCUSSION POINT 22

Should legal representation at the PSC level be permitted? Submissions in favour of its introduction should provide evidence that the current system is unfair.

It would be ideal for midwives and nurses be allowed legal representation or at least the support of highly skilled advocates / negotiators to assist in the deliberations with the highly skilled advocates / prosecutors from the HCCC.

DISCUSSION POINT 23

Are the rules regarding the admission of evidence by PSC's and the Tribunal appropriate?

The rules regarding admission of evidence remain. There is some apprehension with the fact that the HCCC is both investigator and prosecutor of complaints. In this area we would agree with the AMA in its call for complaints to be handled in an impartial manner.

DISCUSSION POINT 24

Should the Nurses Act specify a time limit, which may include the option of extensions, for the making of decisions following hearings by PSCs and the Tribunal?

Yes, because in some situations there are considerable delays between the hearing and the decision being handed down. Decisions by the PSCs should *usually* be able to be handed down within three months following the hearings unless extenuating circumstances require an extension. Protracted delays affect the midwife or nurse's capacity to function effectively, both professionally and personally and are not in the best interests of protecting the public

DISCUSSION POINT 25

Is it appropriate that PSC and Tribunal hearings take place ex parte? If so, should the power to proceed ex parte be expressly set out in the Act?

All attempts should be made to inform the midwife of a complaint against her. Hearings should not proceed without the subject of the complaint being informed in writing and having the opportunity to avail herself of the proceedings wherever possible. This should be spelled out in the act. Current addresses are updated annually from the annual practising certificate.

DISCUSSIONS POINT 26 AND 27

Is the range of protective orders available adequate? Should the Nurses Tribunals power to award costs be modified?

The status quo should remain in both of these areas at present.

DISCUSSION POINT 28

Should the Board be authorised to release tribunal decisions to accreditation authorities in other countries as well as interstate?

Yes. It is important to have consistency and to protect the public. If NSW sees fit to de-register a midwife/nurse, then other states (/countries) need to know this and why.

DISCUSSION POINT 29

Comments regarding the Nurses' registration board emergency powers

The emergency powers are satisfactory

DISCUSSION POINT 30

Are the existing appeal mechanisms appropriate?

There should be some debate as to whether the appeal should be limited to points of law only, rather than the findings of the fact.

DISCUSSION POINT 31

The operation of the impaired nurses system

The status quo should remain.

DISCUSSION POINT 32

Submissions relating to the size and composition of the Board and the mechanisms by which members come to be nominated for appointment to the Board, are invited.

The Nurses and Midwives Board's composition will require modification to reflect the joint partnership of the two professions. We recommend that the membership include 2 registered midwives, experienced and in current practice and a midwife representative of the NSW Midwives Association Inc. There is no justification for the NSW College of Nursing to *automatically* being given a place on the Board and if this continues to be so then a representative from the NSW Midwives Association must also be appointed.

DISCUSSION POINT 33

Comments are invited on the appropriate term of appointment for Board members and whether a limit on the number of consecutive terms a Board member can serve should be introduced.

There should be a limit to the term. This should be enough to ensure quality and expertise but also to ensure opportunities for new Board members and new blood in keeping with the needs of the profession, to be appointed on a regular basis. Perhaps a maximum of three terms, that is nine years, but the Board needs also to be seen to be open and transparent enough for the profession to evaluate its performance and give feedback on a regular basis.

ADDITIONAL POINTS

It is important that wherever 'registered nurse/nursing' is mentioned in the Act, that the Act be amended to include 'registered midwife/midwifery'.

The Act must be rewritten in a way that the public can understand it. Given that many nurses and midwives themselves cannot decipher the language and meaning of the current Act it is reasonable to assume that many members of the community similarly cannot. Adoption of the 'plain English' approach, similar to that which is now used in most insurance and other legal documents that the public are able to access, would be a further improvement and contribution to informing and protecting the public.

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APPENDIX F: PRESIDENT'S REPORTS 1999 TO 2003: LEADING THE PROFESSION – MAKING MIDWIFERY VISIBLE

president'smatters

CHILDBIRTH INTERVENTION INQUIRY *creates opportunities for midwives*

It is indeed a great privilege to be elected as the next president of NSWMA – in what is an exciting and critical time for midwives and midwifery.

We are facing a number of questions that will affect how our profession functions in the next millennium. Internationally and nationally there is debate and conflict regarding the role and scope of the practice of the midwife. Do you believe that we should broaden our role to become 'reproductive health workers'? Or do you think that our capacity to make a difference to health outcomes for women and families lies in strengthening our current role as defined by the WHO/ICM? I urge you to contribute to this debate.

As many of us know only too well, there is currently a national shortage of midwives and an ongoing problem with recruitment. In settings where there are not enough midwives, should we give away any aspects of our role? How flexible and committed are we to creating work practices and models of care that ensure an adequate level of care and safety for all women? How can we make midwifery a more attractive career choice?

NSWMA has been involved in several critical activities recently that address these questions. For example, I recently participated in a two-day National Nursing Workforce Summit in Canberra – along with ACMI representatives including our new national president Vanessa Owen and 170 nursing and midwifery leaders – to debate the future directions of our profession to the year 2010.

Amidst the difficulties facing

midwifery, there are also enormous opportunities – both political and professional. The national ACMI conference in Hobart and the Commonwealth Government Senate Inquiry into Childbirth attracted a large amount of media attention. Midwives across Australia have played an important role in highlighting the increasing and unacceptably high levels of intervention in childbirth. Senator Rosemary Crowley, Chairperson of the Inquiry, was reported as saying: "Midwives were highly organised with provision of evidence and sound rationale for more women-centred models of maternity care". Hopefully we are on the brink of seeing significant developments in terms of more equitable, accessible, evidence-based models of maternity care across Australia.

NSWMA has forwarded a submission to the NSW Department of Health's *Review of Nurses Act 1999* in which we have presented the case for a Midwives & Nurses Act. This work incorporates suggestions from many of our members and recognises the membership's rejection of our initial pursuit of a separate "Midwives Act". May I take the opportunity to thank all of you who contributed, especially those who assisted in the huge task of completing the substantive and significant submission. If we are successful, NSW will lead the way in demonstrating the potential for nurses and midwives to coexist in a way that is mutually respectful and beneficial for both the professions and the public.

We have a number of new faces representing us at both state and



national level and it is hoped that everyone will continue the good work of their predecessors in steering the College onwards and upwards. The new NSWMA Executive Committee is committed to hearing your concerns and acting upon them. We can only do this with your support and contributions; be they letters, hands-on time assisting with tasks, or signing up a new member. Share your ideas. Be active. Be positive. Together let's get midwifery blooming!

Pat Brodie
President

Pat Brodie is currently employed as Research Midwife, Australian Midwifery Action Project, University of Technology Sydney and Consultant Midwife, St George Hospital, Kogarah.

SPREAD THE WORD!

Here we are now, well into the beginning of the new millennium, and many of us have had the benefit of summer holidays and a period of restoration and rejuvenation. For those who have not been so lucky, I hope that there is some time put aside for rest and recreation soon and a replenishment of your energy. Our work as midwives is hard. No matter whether we work closely with women, teach the next generation, manage and lead services, or work indirectly through research and political activity, we all work hard to improve the care provided to women and to enhance the profession. Recognising this is critical. How can we care for women and babies if we do not care for ourselves and each other?

Recently we heard of a potential midwife deciding against enrolling in midwifery studies because of the way she had been treated during her clinical placement as an undergraduate nurse. We cannot afford this. We need to actively pursue potential new midwives, to nurture, support and encourage them. The crisis in our workforce numbers at present will require strategies at every level of government and health services and for you to also contribute in any way that you can, to bring people into midwifery.

NSWMA has continued to inform the NSW Health Department, through the Chief Nurse, of the major issues currently affecting midwifery and maternity services. In late 1999 we also had a formal meeting with the office of the Minister for Health, Mr Knowles. This meeting was followed up with a



"We have been able to put midwifery 'on the agenda' of the Health Department..."

meeting with the NSW Health Council, a body charged with the responsibility, within six months, of identifying a range of reforms and solutions to relieve pressures on public health services and those who work in them. At both of these meetings we highlighted several critical issues that require urgent attention and presented some practical solutions and suggestions for change. These included expression of our extreme concerns regarding:

- pressures on smaller regional units to close or reduce maternity and midwifery services without justification or adequate consumer consultation;
- capping of maternity bed bookings as a cost containment strategy,

making it impossible for some women to book at their local hospital;

- lack of implementation of evidence-based models of care that improve outcomes, increase the use of midwives' skills and reduce medicalisation and costs;
- the widespread adoption of the early discharge option without appropriate community midwifery care and follow up; and
- cost shifting of maternity services from state to federal funds without consideration of the effect on women's experiences.

We have been able to put midwifery 'on the agenda' of the Health Department and reinforce the benefits of midwifery and of midwives playing a more active role in mainstream maternity care. We will continue to do this and to fulfill our commitment to achieve a strong, united and well-recognised profession that benefits the community.

The new year will bring us into what may be a new era for midwives across NSW. As I write this report some months prior to publication, it is impossible for me to know if we are indeed about to have a new Nurses & Midwives Act. Whether we are successful or not in this regard, the close consultation and development that has occurred in the development of the review of the Act highlights significant progress and growth for us as a profession. There is no better time to be a midwife. Spread the word!

● Pat Brodie is a Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney and Consultant Midwife, St George Hospital, Kogarah.



CHANGE IS IN THE AIR

decisions on behalf of our members. One of the biggest changes involves our name. After much deliberation and clarification of our legal position we will become

are privileged to have Senator Rosemary Crowley, Chair of the Senate Inquiry into Childbirth Procedures, as our special keynote speaker. In delicious contrast, the conference dinner speaker will be witty author Kaz Cooke, author of *Up the Duff*. These two days will be memorable so register early and don't miss any of it.

Collaboration is emerging as a critical factor in the development of women-centred maternity care. As we grow in confidence as midwives we are reminded of the importance of working with others to achieve the 'best' care for women, their babies and families. At a clinical level this is essential though undervalued. Our professional associations must also include collaboration. We recently renewed contact with RANZCOG and the NSW Nurses Association to confer, debate and share issues of mutual concern with the medical and nursing profession. We aim to improve the level of trust and recognition of midwifery as a profession, and also incorporate and learn from others who play a vital role in providing health services to women. This, in conjunction with the increasing recognition of midwifery at Commonwealth and State health policy level, assists us in our pursuit of midwifery autonomy and influence over major decisions regarding the organisation of maternity services. There is a long way to go but together we will embrace the changes and 'make midwifery matter'. ■

● Pat Brodie is a Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney, and Consultant Midwife, St George Hospital, Kogarah.

Change is a theme for many of us in our everyday lives. Many midwives are currently immersed in the challenges of changing models of care, practices and roles, which brings with them changed attitudes, values and philosophy. For many this is welcome and positive, for others it may be overwhelmingly difficult. The way we adapt to and manage the changes can have profound effects, both individually and professionally, and we need to weigh up the potential benefits and risks. This requires excellent interpersonal communication, confidence, courage and trust. These attributes are not acquired overnight we must support each other in facing the challenge of change. In doing so, we can continue to improve midwifery and the care provided to women.

ACMI-NSW and the national body have experienced massive changes over the past year. These include new executive committees, new leadership, new offices, strategic planning of new directions and completely new office systems. It is both an exciting and demanding time. Many of us have had to learn new skills, unrelated to midwifery, which have taken time and resources to acquire. The financial operations of the Association have also been reviewed and upgraded so that we are working at maximum efficiency and able to make sound

known as the Australian College of Midwives Incorporated – NSW Branch (ACMI-NSW). This heralds a major step forward in our pursuit of a shared national identity and our intention to stand united with midwives across Australia as members of one College. We will continue to represent the independent and particular views and needs of NSW midwives whilst working with the national executive on key initiatives. I would like to thank all who have contributed to this debate and the process of changing the name.

Another anticipated change is the results of the review of the Nurses Act in NSW. Let us hope there is some news for the next newsletter that gives us cause for further debate, challenge and change!

Keeping in touch

The executive has continued to reach out to the membership through the quarterly Forums. These are ideal for keeping up with what is happening at a local level, hearing issues and concerns, and seeing what we have been achieving at executive level. Come along next time. We are aiming to conduct these in regional areas so contact us if you can help arrange a forum in your area. Through our strategic planning processes we aim to incorporate suggestions from these types of consultation processes.

For this year's state conference we

LEADERSHIP IN OUR LIVES

At our conference last year, Wendy McCarthy inspired us with her challenging paper proposing the idea that "leadership is everybody's business". I have been exploring the issue of leadership recently and it seems that indeed, it has multiple meanings in everyday life. For some, it has connotations of management, hierarchy and authority. For others, it equates with passion, drive and enthusiasm. No matter what it means in everyday life, leadership is about power.

The future of our profession depends on excellent leadership and powerful confident midwives. The way in which midwifery is shaped and developed in Australia over the next few years is dependent on midwives showing leadership and initiative. In every state and territory, changes in legislation, regulation, education, industrial arrangements and models of care – to name a few – are being pursued in the best interests of women, communities and the profession of midwifery. There is the suggestion that the majority of midwives do not want these radical reforms, that the 'vocal minority' is driving them. In the light of such challenges, it is critical that the need for change is voiced and supported, not only by opinion formers and decision makers in the profession, but also by the many midwives in everyday practice; that is YOU.

You may not see yourself as a leader, or you may not have time to get involved with the professional issues

affecting midwifery at this time. But, it is crucial that you recognise your rights and responsibilities regarding the leadership of our profession. If it is not going in the direction that you think is best, you must speak out.

Good leaders and leadership come from the grassroots membership of an organisation. It is important that potential leaders are identified from within the community of midwives: that they are nurtured, encouraged and supported to put themselves forward, to speak out about and for midwifery. Without them there would be no debate, no development and no change. Good leaders use evidence and experience to lobby for change. Share your experience and ideas, feed them in the direction of those who have a responsibility to listen and respond.

Leadership comes through our work in many ways: the way we support students and new midwives, the way we communicate with each other and our colleagues, the way we provide education and engage in research, the way we lobby for change. We all do our bit in leading midwifery. We may have different ideologies and attitudes, but if we care about the future of our profession, we need to support each other. We need to reflect, debate, explore, share ideas and challenge each other with respect.



ACMI-NSW President
Pat Brodie

In doing so, we are leading.

As we prepare for our annual state conference this year in Wollongong, let us consider how we can help each other become more powerful – as midwives and as leaders. The networking that takes place at these events is a powerful platform for debate, discussion and discovery. We always learn something new about our work, our roles and ourselves. In the spirit of the conference theme, I encourage you all to ride the waves of change, even when it feels as though you are swimming against the tide in deep, uncharted waters. Together we can create a sea of change in midwifery! ■

● Pat Brodie is a Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney, and Consultant Midwife, St George Hospital, Kogarah.

EQUALITY AND INCLUSION

powerful principles for our profession

Recently there have been several discussions between midwives about how they feel somewhat excluded by their colleagues if they are not practising 'directly' in clinical midwifery. These days we have a broad range of career opportunities and equally important, there are many crucial roles that should be filled by skilled midwives. How do we balance these opportunities and responsibilities with a perception that 'if you are not hands on, you are not one of us'?

Equity and inclusion – powerful words, full of connotation, and of varying importance to each of us. These terms are important principles in midwifery. What do they mean to you? Have you ever experienced not being included, or being treated 'differently to others'?

Wherever we are working in midwifery we would have encountered situations where these principles have not been upheld. We may have seen clinical care that was 'exclusive' in that it was reserved for women who 'were informed' or who 'could afford it', such as access to childbirth classes, birth centres or luxurious postnatal accommodation. Some may have seen antenatal services that were inequitable, in that they were not available to all women, or excluded women because of their age or parity.

Equity and inclusion are powerful, political principles that highlight our views and attitudes about others and also how we see ourselves in relation to others. Whether we believe we are

'better' or 'lesser' than others, based on our personal values and self-concept, affects the way we communicate and provide care. This goes for the way we are 'with women' and also the way we are 'with each other'.

Our values affect our practice. If we believe that all women are equal and deserve access to the best care available (regardless of age, social class, sexual preference, ethnicity or cultural beliefs), we are in a position to truly support women's choices. And we can help them access what they need, rather than what we think they should have.

If we believe that some women don't deserve the same as others, then our practice is inequitable and discriminatory. Perhaps, none of us could identify with either extreme, though we are frequently confronted with caring for women who evoke challenges to our values. Whether it is women's choices regarding abortion,

surrogacy, teenage motherhood, smoking, bottle-feeding or refusal of treatment, it is indeed a skill to continue to be 'with woman' at times, when we do not approve of the path she has chosen.

The same applies to midwives career choices. Midwifery work encompasses many roles, all of which are critical to improving care for women and babies; and to improving the midwifery profession. We need midwives with experience and knowledge in a variety of roles to be placed throughout the entire health system. In doing so, we can uphold the important principles of equity and inclusion and thereby ensure a 'voice' for all midwives. ■

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NSW Midwives
Association President
Pat Brodie



DECEMBER 2000 5



NSW Midwives
Association President
Pat Brodie

LOOKING AT A bright future

Review, reorganise, refresh, renew' – these are my buzzwords for 2001. This year will undoubtedly see considerable change for NSW midwives. At the time of writing, we are about to start reviewing our operational functions at the NSWMA office with a view to improving the services we offer to our members and the role we must fill in representing the profession of midwifery.

Last year heralded unprecedented growth, expansion and success for us, as an organisation and business. Membership is up, our educational seminars, conferences and learning packages are positively blooming and we are increasingly requested to contribute expertise to a vast range of reports, policies and committee work.

Last year also plunged us into enormous challenges and occasional crises as we struggled to provide the woman-power and resources to fulfill many more demands. Changes to the taxation system and all of our financial reporting systems further contributed to what was a very difficult latter half of 2000. We have responsibilities to you, our members, that we are well

aware of and we have exciting new ventures that will assist us to expand and be more resourceful and accessible to more midwives. I pay tribute to all of the staff, executive and subcommittee members and the many midwives who freely contributed their time and effort to enable us to survive and stay afloat.

By the time this newsletter is in your hands, we will have finished the review

and started the process of reviewing, reorganising, refreshing and renewing our roles and functions in the office. We will probably need to expand the number and type of staff available to do the work that is required. We also need more casual educators to contribute to our many seminars and workshops (see the advertisement on page 11; these are paid positions). We will also need casual holiday relief for our busy office staff. So if you feel you have the skills, attributes and time please get in touch.

We also require new people to join our many sub-committees. These include Marketing and Promotions, Newsletter, Education and Research, State Conference Planning, History and Archives, and Membership Committees. These roles are voluntary but the rewards come in terms of great fun, creativity, good food, new skills, networking with colleagues and having a sense of 'putting back' into your profession and ensuring a healthy future for the next generation of midwives. We are particularly keen to hear from student and new graduate midwives as well as rural and remote midwives. Teleconferencing can be

arranged for most meetings for our country colleagues.

Whilst on the trail of 'review, reorganise, refresh, renew', this year also brings us to another election and the chance to encourage new members to join the Executive Committee. The current Committee welcomes feedback and suggestions for improvement and there is no better way to show your support or critique of our performance than by nominating and voting the next Committee into office.

Meanwhile, we are anxiously awaiting an outcome of the Review of the Nurses Act in NSW. This has been a protracted process, one that has been detailed and thorough and it is hoped that the final recommendations do justice to the obvious effort being put in by all involved. 'Review, reorganise, refresh, renew' also represents our hope for a modern regulatory framework for midwifery that is reflective of international standards and which recognises the unique contribution of midwives to the care of women and babies. I anticipate being able to report the outcomes of this review in the near future.

Adaptation to what is an ever-changing environment and making the most of opportunities to enhance midwifery is one of our key responsibilities. In order to do this we must take the time to review, reorganise, refresh and renew our structures, systems, policies, practices and indeed ourselves, to keep, maintain and advance our organisation and the profession of midwifery. I do hope all of you see the benefits of these efforts and keep us vigilant in our endeavours. Write, phone, fax or email us with your thoughts and ideas for further enhancing midwifery across NSW. ■

● Pat Brodie is Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney, Consultant Midwife, St George Hospital, Kogarah and President of the NSW Midwives Association.



for the majority of women. Almost every day, in some way, we are called upon to defend midwifery and give a rationale for why the services of midwives need prioritising in the healthcare system.

Raising the profile of our profession

One of our biggest challenges is the invisibility of midwifery and midwives at every level of the current system, and in the eyes of the public, who usually cannot distinguish a midwife from a nurse. The NSW Health Council Report is just one example of midwifery's invisibility within the planning and policy direction of acute

The road ahead

The challenge ahead is to continue to use evidence to demonstrate our effectiveness, but also to work at the political level to ensure that we gain a legitimate authoritative voice. In NSW we have been successful in gaining recognition on a range of issues affecting midwifery, through the Office of the Chief Nurse. This is significant to the improvement of maternity care in this state. We need to build on this recognition and work together to find a voice in those areas where midwifery is most invisible.

The extent to which we might ultimately transform the profession and influence the policy and systems of

WHY MIDWIFERY MUST BE A PRIORITY

As the next state and national conferences draw closer, it is timely to think about the major professional issues on our doorstep. For midwives in NSW, the outcome of the review of the Nurses Act is one of those issues.

At the time of writing, I have heard from the Chief Nurse Judith Meppem that, once approved by Cabinet, the report will be posted on the Health Department web site and we will be notified of the outcome in writing. Then this will be followed by further consultation during the process of drafting the new legislation before it goes to Parliament, probably in the second half of 2001.

The importance of midwifery

The professional challenges currently facing midwives are many. Increasingly, we are being called upon to justify why midwifery is important and why a 'medicalised' approach to care in pregnancy and birth is inappropriate

health services. Anyone reading this large, influential document is challenged to find more than a couple of references to midwifery services or midwives.

Many hospital administrators do not identify midwifery staffing needs as distinct from those of nursing. Compounded by the crisis of a diminishing workforce (particularly in rural areas), this often means that opportunities to practice to the full potential of the midwife's role and scope of practice, are limited.

Visibility is fundamental if we are to gain control of the legal and industrial systems that govern midwifery. It is vital that, as midwives, we continue to raise the profile of midwifery in the community and in our everyday work, whether it is in relation to decisions about midwifery care, managing a unit, influencing policy decisions, or in dealing with the media. We need to support each other in seeking an identity that is strong and clear, an identity that is credible and respected.

maternity care in NSW is dependent on the emergence of a strong identity and an authoritative voice for midwifery. To do this, we need strong midwifery leaders who are able to influence change that will ultimately improve the experience of childbirth for women and their families.

In this issue of *Midwifery Matters* we focus on midwifery students and highlight the important issues and challenges that they face. As registered midwives, we must embrace the responsibility of caring, supporting and guiding this next generation of practitioners. Hopefully they will emerge with a strong midwifery identity and will continue to develop and transform our profession as the next generation of midwifery leaders.

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UNITY in midwifery

BY PAT BRODIE

Having survived the chills of winter, it's time to think about the new growth we wish for our profession.

Currently, the midwifery that many of us know and love is changing. Big questions are being asked about the way midwives are educated, employed, insured, regulated and represented. There are a number of reasons for this including a workforce shortage and the imperative of policy makers to find low-cost answers to the spiralling costs of maternity service provision. And, within a context of increasingly medicalised birth, it is getting harder for midwives to be 'with women' and to provide a comfortable level of adequate care.

The way maternity care is provided in the future will possibly have more to do with expediency and efficiency, than with the preservation of midwifery culture and ideology. As a result, the current professional issues for midwifery are enormous. We will be called upon to demonstrate the effectiveness of midwifery and the quality and standard of practice that makes a difference to health outcomes and women's lives, and their families and communities.

Within such a climate we must strive to ensure that we are visible to women and to policy makers, that midwifery is organised and strong, and that midwives remain competent and confident. How do we do this? All of us can and must contribute. We do this through the provision of ideas, advice and answers (when we have them), to the big questions that are being asked about the way midwives are educated and employed and the way maternity care is provided. This can be done at many levels, locally through the clinical practice setting, and in universities,

health services and offices of government agencies and politicians in the wider system.

Some current examples of this professional 'work in progress' include the work of the College in the development of new national standards of midwifery education; discussions about the need for improved midwifery regulation; revision of the Competency Standards; revision of the College Constitution and submissions to two Commonwealth reviews of nursing and midwifery. NSWMA works closely with the ACMI to ensure that these vital issues are addressed in a way that meets the imperative to have an effective midwifery workforce and a profession that is comparable to the best midwifery anywhere in the world. Be sure to have your say on these important matters that will shape the future of midwifery.

The struggle for recognition of midwifery as a separate profession and the imperative to address increasing the medicalisation of maternity care are just two of several huge challenges currently with us. Another is the suggestion that a less qualified health worker in midwifery may address the needs of women while contributing to a decrease in spiralling health care costs. The 'post natal support worker' and the 'doula' are emerging in Australia – as they have done elsewhere, in response to a gap in care previously provided by midwives.

Emotional support, provision of information and the development of trust and confidence are the hallmarks of midwifery. But, in the current system of fragmented care where women are often left alone in labour because of insufficient numbers of



midwives, length of stay is brief and community postnatal care receives minimal funding. Inevitably, at times it is impossible to ensure adequate midwifery care.

As in the past, there will always be hurdles that seem insurmountable. Clearly, there is still a long way to go and the answers lie in: unity within the ranks of midwives wherever we work, increased membership of the College and the articulation of a clear structure and direction for the future.

Now more than ever we need every midwife to be a member of the College. Through increased numbers we have a stronger voice. We have achieved much in NSW and nationally and it is only through a strong and united College that change will happen, for women and their families as well as for this most precious profession.

● **Pat Brodie is Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney; Consultant Midwife, St George Hospital, Kogarah, and President of the NSW Midwives Association.**

Into the future

By Pat Brodie

I am delighted to be writing this report following my election as your President for a second term. This is an exciting time to be part of the growth and development of midwifery in Australia. The NSW Midwives Association has been very successful in contributing ideas and strategies towards a range of innovations and achievements that will benefit midwives and, ultimately, the users of maternity services. As discussed in the last edition, the 'work' of the College has been considerable and will continue.

Fresh faces

We have a number of new faces on the executive committee for this term. Diane Zalitis gives fresh input for rural midwives and Angela Deken brings experience as an educator and practicing midwife from New Zealand. We welcome you both and thank you for coming forward to influence and support the work of the Association. We say thank you, also, to Carolyn Hastie, Pam Mulholland and Rosalee Shaw for their contributions over the past term of office, during which time we saw enormous change and expansion of our organisation, in particular of the financial and office management systems.

Challenges and opportunities

Since the last newsletter we have enjoyed the National Conference in Brisbane and experienced the challenges and the opportunities that present at such a major professional gathering. In what will be seen historically as an auspicious event, there were several big decisions made by the membership at the Annual General Meeting that will



"In an increasingly litigious workplace, the question is whether any midwife in practice today can afford not to have such cover."

significantly change the direction of the ACMI forever.

These two decisions were, firstly, in a changed constitution, to admit consumers and student midwives into the College as full voting members. The second decision was a vote that supported the relocation of the national offices of ACMI to the national capital, Canberra. These changes will take effect just as soon as the formalities and arrangements can be made, but certainly they will be achieved over the next 12 months.

Important decision facing members

Another very significant decision facing all members right now is whether to take up the opportunity of procuring legal benefits and professional indemnity. In an increasingly litigious workplace, the question is whether any midwife in practice today can afford not to have such cover. What is of extra importance in this decision, however, is the potential that we are all being presented with to support our independent midwife sisters across the country. By all of us taking a united stand and accepting the insurance offer, we are also proclaiming in one voice that independent midwifery matters – to all midwives. Again, historically this will go down as an auspicious decision for the profession.

The dawning of a new era

All of these big decisions will assist the College to scope its future. How we work 'with women' as College members will articulate our values and our beliefs for how we wish midwives to practise and provide a service to women in any setting.

This is a new era for Australian midwifery and together we must share our ideas, our knowledge, our fears and our concerns. By supporting each other and encouraging open discussion and debate we all will share the responsibility for where midwifery is heading. Will you lead or will you follow? MM

■ Pat Brodie is Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney, Consultant Midwife, St George Hospital, Kogarah and President of the NSW Midwives Association.

Communication is the key

By Pat Brodie



In the December issue, I wrote of the importance of equity and inclusion in midwifery. These powerful political principles reflect our views and attitudes and how we see ourselves in relation to other people. In the same report I suggested that we should respect each other's different ways of working. As midwives we work professionally for the improvement of care to women, across different spectrums, for different purposes and in many different roles.

Challenge to the profession

Recent challenges to the profession, such as the loss of indemnity cover for independent midwives and proposed changes to the legislation and regulation of midwifery, have challenged our commitments to the principles of equity and inclusion. Through our concerted efforts on these matters it has been suggested that we are focussing on only a minority of midwives. Simultaneously we have been criticised for not being focussed enough on these issues.

"We may not agree with what our colleagues say, but we need to confer, communicate, challenge and collaborate at some basic level of respect if we are to achieve our aims."

The pursuit of indemnity cover, and the suggestion that all midwives could share the financial commitment that might enable independent midwives to continue to practise, challenged us as a group. The ballot process that was developed following the best available advice was problematic and the results equivocal. This has been addressed elsewhere by the national President.

What has emerged from this process, however, may be far more challenging professional debates about whether we are all one profession and whether we are all 'woman-focussed'. Clearly, if we practise in different ways, we will have different priorities. What is significant may be not so much 'what' we do, but 'how' we do it. Whether this is in everyday practice as midwives or how we run the professional association, the process side of what we do will probably get more attention than the outcome.

While this may seem bizarre, it is self-evident if you reflect on our everyday communication. The simple example of 'asking nicely' when needing help will achieve positive results more often than if we are demanding or abrupt.

Processes of communication

Professional relationships are processes of communication and consultation. The way we communicate and consult centres around the need to collaborate. We may not agree with, or even like what our colleagues are saying – but we need to confer, communicate, challenge and collaborate at some basic level of respect if we are to achieve our aims. Like communication, collaboration is an evolving forum that allows us to address a problem or a need. Collaboration gives us structures to build new relationships

and understandings, which may lead to better communication, better processes and improved outcomes in the future.

A forum for all

Writing in this newsletter is our way of communicating and collaborating. It is a forum for both you and the Association to contribute to the professional growth and enhancement of midwifery in NSW. We seek to ensure a diverse range of opinions, views and ideas from the spectrum of midwifery and maternity care. We hope to challenge and engage in thinking and creative formation of new ideas and directions for our profession. We seek professional relationships with our members and ask them to tell us what is important and significant to them. Write to us – even a few words give us the chance to adapt our contributions to the profession so that we remain equitable and inclusive of all midwives. **MM**

■ Pat Brodie is Research Midwife, Australian Midwifery Action Project, University of Technology, Sydney, Consultant Midwife, St George Hospital, Kogarah and President of the NSW Midwives Association.

Our future is in our hands

By Pat Brodie

As you will have noted in the Stop Press section of our March newsletter, NSW Health has released its report, *Review of the Nurses Act 1991*. NSWMA is delighted with the recommendations contained within this report and NSW Health must be congratulated for providing a considered, well-balanced and well-substantiated report.

Of most significance is the recognition of midwives throughout, with recommendations for a separate register for midwives, renaming of the board to the Nurses and Midwives Board and the development of two separate standing committees: the Nurses Practice Committee and the Midwives Practice Committee.

While there are a number of details the NSWMA will pursue, as your professional body we are most satisfied with the progressive nature of the report and its capacity to inform more appropriate regulation of midwifery for the future. The public will benefit from improved information, easy identification and greater recognition of midwives.

Making midwifery visible

We have led the country in the pursuit of changes to the Act and greater recognition of midwifery and its place, both separate and alongside nursing. As members, I urge you to respond to these changes in as many ways as possible, to make midwifery visible at every level within your professional and social environments.

Use the title by which you are registered – 'midwife' – and remind consumers and colleagues that following the enactment of the proposed NSW Nurses and Midwives Act, you

will indeed be legally recognised as such. It is important that the public is aware of who is providing care and that midwives are essential for the provision of safe maternity care in any setting.

Worrying picture

The current challenges facing rural and small maternity units should be of concern to all midwives. As highlighted in the previous newsletter by Elaine Dietsch, sustainability of birthing services in these units is being

"The current challenges facing rural and small maternity units should be of concern to all midwives."

questioned all around the country. Withdrawal of obstetric services, midwifery workforce shortages and concerns about standards of practice when the numbers of women are few, all combine to paint a worrying picture.

Clearly there are examples from other countries where midwives have joined with women to fight for the survival of maternity services, especially those provided by midwives only. There is considerable evidence cited elsewhere in this newsletter that should convince any policy maker, obstetrician or health executive that well-organised and supported midwifery-led care, provided by skilled and competent midwives who are up to



date with practice and able to respond to the needs of women, is safer than (not just as safe as!) conventional care for low-risk women.

So why should we all be concerned?

Because if midwifery-led care is not soon to be recognised as safe for low-risk women, then many more women and midwives, not just those in rural areas, will be disadvantaged. The current diminution of obstetricians from the maternity services is certain to continue and women will be expected to transfer to larger units in order to remain under medical surveillance.

This surveillance, no matter how peripheral, is also a surveillance of midwifery practice. If there is no medical surveillance possible then midwifery care will not be 'permitted' and local midwifery services will also diminish and cease. Women and midwives together must address this social and political crisis and seek to inform and educate others who may or may not see the logical sequelae of rejecting the considerable evidence that supports midwifery-led care as a safe and effective choice for women.

Keeping Birth Normal

Within the midwifery literature emerging from Britain, New Zealand, Canada and Australia there are repeated references to the concept of 'keeping birth normal'. More recently there have been conferences, workshops and the announcement of a new journal devoted to the subject. The call for 'keeping birth normal' reflects much of what is ailing our maternity care system and the reasons midwives give for leaving the profession. Within a climate of diminishing workforce numbers, reduced opportunities for midwives to practise their full range of skills and an acceptance of medicalised childbirth as the norm, 'keeping birth normal' is possibly one of the biggest challenges facing Australian midwives.

We are challenged to keep birth normal within the context of supporting women's choices. It is imperative that all women are aware of the consequences of 'choosing' an intervention such as induction or epidural. As midwives we must be well informed of the latest evidence about such 'choices' and assist women to be fully informed and able to ask such questions as "How will this affect my chances of having a normal birth?" We should question the validity of the concept of 'informed choice' within a maternity care system, that sees a healthy woman with a normal pregnancy and birth readily able to 'choose' a caesarean section but unable to choose her own midwife or place of birth. The personal, social and economic consequences of this are increasingly being revealed and will give strength to

the growing argument for 'keeping birth normal' as a strategy to improve health outcomes, improve women's experiences and reduce the spiralling and unnecessary costs of maternity care.

Within this context, NSWMA have continued to pursue its goals and responsibilities of supporting and enhancing midwifery across the state. In the current increasingly medicalised maternity services and systems, midwifery itself could well be seen as a cost-effective intervention and overall strategy aimed at improving outcomes. With financial assistance from the Office of the Chief Nurse we have commissioned the development of a 'Midwifery Re-entry Learning Package' that will assist midwives re-entering or refreshing practice skills and knowledge. We look forward to the release of the discussion paper 'Options for the development of Homebirth Services in NSW' commissioned by NSW Health Department earlier this year.

Our new constitution has opened the door for greater liaison with consumers as members. We have met with members of Maternity Coalition and fully endorsed their National Maternity Action Plan which provides the framework to develop community based maternity services that are evidence based, woman-centred, cost effective and more likely to 'keep birth normal'



for greater numbers of women. We look forward to an increasing number of consumers joining our Association and enhancing our efforts to ensure an informed community of maternity service users and providers.

'Keeping birth normal' requires skilled confident midwives and informed, confident and well-supported women. Achievement of these goals can be enhanced through communication, education and raising of awareness. We do this in a variety of ways through our informal and formal networking, the NSWMA newsletter, workshops, meetings and conferences. November 1st & 2nd 2002 provides us with just that opportunity with our annual state conference at Byron Bay in northern NSW. See you there!

• Pat Brodie is President of NSWMA. She is currently employed as Senior Clinical Adviser, Maternity Services at NSW Health Department.

PRESIDENT'S Matters

by PAT BRODIE

Difficult Times

It has been a challenging and difficult year for midwifery and for many midwives across the state. In different places in NSW and indeed Australia, workforce shortages have hit hard and the challenge of ensuring adequate care for women in all settings has been almost impossible to meet at times. It may seem that metropolitan maternity services aren't nearly as hard done by, but increasingly we are hearing reports from our members about the extreme shortages and lack of basic levels of midwifery care being provided in all settings.

Every midwife has felt the effects of workforce shortages. The recently released Commonwealth government Midwifery Workforce Report is the first formal attempt to quantify the severity and scope of the problem. On behalf of NSWMA we have contributed information and matters of critical importance to the review in order to get the message heard and understood. The message is that we are very short of midwives and we do not have an effective plan to make sure that this shortage is addressed! For the first time, a report also is able to quantify and verify the fact that there are a large number of nurses without midwifery qualifications working in midwifery. The extent of this problem and its effect on the care and outcomes for women and their babies will be variable across NSW but nonetheless it is a major concern that health authorities and education providers must come together to address. You can be assured that we will continue to demand this and seek opportunities to find solutions to the workforce and educational crisis in midwifery.

Much of our work in the Association is about seeking greater visibility of midwifery and the role of midwives.

This includes addressing the big issues that exist as barriers to us being able to fulfill our role. The current workforce shortage is one of those barriers. In some units it means not having registered midwives on some shifts. In others it may mean student midwives being left unsupported in their clinical placement. One bottom line for us must surely be: Provision of one to one care from a registered midwife for ALL women in established labour is surely a fundamental criterion for minimum safety in any maternity service. Sadly, this is not achievable for many women in NSW



or Australia and we have much to do to raise concerns in this regard.

The year has had many achievements for us including several successful seminars, the development of additional learning packages and a continued media and political profile to draw attention to issues of major concern. We have persisted in pressing the Department of Health for the release of the Homebirth Options Discussion Paper, seeking the assistance of the NSW Nurses Association through our combined Midwifery Reference Group Forum.

In September we were privileged to join the launch by Maternity Coalition of the National Maternity Action Plan which provides an evidence-based blueprint for the development and implementation of community based midwifery services. We will continue to work with all consumers to see an expanded range of choices and models of care and greater access to midwifery care in any setting. The annual state conference in Byron Bay in November showed us again what we can achieve when we work together to support each other. Together we must continue to make midwifery matter and give birth to a new age of powerful birthing, powerful women and powerful midwives!

Call for Nomination for Executive Committee 2003-2005

The NSW Midwives Association Executive Committee is due for re-election at the Annual General Meeting on 26th July 2003. Members interested in being elected to the Executive Committee for the next term and for a period of 2 years should forward an expression of interest with details of their work, qualifications and experience and detail what they can offer members of the organisation for inclusion in the March Midwifery Matters.

Nomination forms can be obtained by calling the office on (02) 9281 9522 or email midwives@zip.com.au. Nominations should be received by January 31st 2003.

Keeping Families First

In NSW, a number of new health care policy initiatives are set to further influence the organisation of maternity care and the role and scope of practice of midwives in the future. By now, many midwives working in the public health system will have heard of the Families First initiative and some may have begun to incorporate its key messages into practice. Gillian Calvert's paper (produced in this edition of the newsletter) provides us with a compelling rationale for the role midwifery can play in Families First and why we must find new ways to support and reach out to women and families most in need. This includes the imperative to meet the woman and get to know her early in pregnancy, working with her to identify stresses and make a full assessment of her needs within the context of her everyday life and family situation. Where midwives provide continuity of care to women they work across the interface of hospital and community services. This means that midwives are able to ensure that support is linked in a timely way to other services that can contribute to improve the lives of women and the health of communities. It is explicit in Families First that, in particular, the services provided to women from marginalised groups, who have the poorest outcomes, must become more individualised, more appropriate and better utilised.

The purpose of Families First is clearly one of strengthening the linkages between services offered by midwives and those provided by community health services. Recognition of the underlying philosophy of this approach as 'primary health care' and the crucial public health

role of midwives is an important step forward in ensuring that these linkages do indeed become stronger and also sustainable in the long term.

Midwives themselves must be able to appreciate 'primary health care' as the underpinning theory of the midwifery model. It is a key to our future. We must fully understand the potential of midwifery as primary health care if we are to embrace these important developments that have the potential not only to improve outcomes but also to contribute to a greater appreciation of the potential role of the midwife.

Midwifery models and practices that are built on the core Primary Health Care concepts will centre on the need for health services to be reoriented to ensure:

- equity of access for all women and their families
- woman's participation and self determination (woman's right to choose) and the development of individual skills and confidence
- socially acceptable and affordable technology (evidence based care)
- timely health promotion and minimisation of risk to women and their infants
- cooperation and collaboration between key service providers
- building of healthy public policy (such as continuity of care) and sustainable projects
- supportive environments for women and communities to learn from each other
- a strengthening of community action and consumer participation

These concepts in their broadest sense reflect international best practice in midwifery. 'Woman centred care' in essence



is primary health care. The role and function of NSWMA includes the continued promotion of these messages regarding the powerful potential of midwifery to enhance a community's well being. We do this through representation to health departments, regulatory boards, university advisory panels and other authorities concerned with standards of midwifery practice and maternity care. Improved organisation and models of care, including the urgent need to develop community based midwifery services must therefore be part of the broader long term vision of the Families First initiative. Each midwife wherever they are in practice also has a responsibility to promote these messages. Every university, developing either Bachelor of Midwifery degrees or post graduate diplomas in midwifery also has a responsibility to ensure that primary health care concepts are 'core' to curriculum development.

Together we can do this more effectively through a strong, articulate and respected professional organisation. This month, take the time to consider what you want from NSWMA in the future, consider the nominations for the Executive Committee, sign up a new member or two, or three and make contact with us through whatever medium you can. Women and midwives can work together to ensure healthy families and communities!

Pat Brodie is the Birthing Services Coordinator at St George Hospital, Kogarah NSW

www.nswmidwives.com

Midwifery Matters 5

Lets Get Our Act Together

The theme chosen for our annual conference this year is 'Midwives & Women: Getting our Act Together'. This is chosen as a means to reflect our long awaited new midwifery regulations in NSW as well as a hope that midwifery continues to grow and develop to better meet the needs of women who are accessing maternity care in any setting. The program that has evolved reflects multiple ways that we will 'get our act together' through practice and policy change and through working closely with women.

When we started planning the conference late last year we were very confident that the new 'Nurses and Midwives Act' would have been released by the conference dates. As I write this report I remain wistful about the journey we have travelled towards the development of new regulations for midwifery in NSW. It was in October 1999 that we submitted our paper to NSW Health Department where we argued for a number of significant changes that would give proper recognition to midwives within the regulations. This included the development of separate registers and standing practice committees for midwifery and nursing as well as a change in name to the Nurses and Midwives Act. In this submission we argued, on your behalf, the need for change in the view and legal positioning of the Nurses Registration Board regarding the identification of midwifery as distinct from nursing. Two years later the report was released for discussion and can be found at www.health.nsw.gov.au/csd/11sb/nursereview/index.html.

At the time of writing this report (some two years after the release of the

recommendations!) I am informed that the bill for these changes has been drafted and is now awaiting the usual parliamentary processes.

Why are new regulations important to midwifery and to the care of women? Why do we need to 'get our act together'? What is so important about changing the Act?

Every midwife needs to know the answer to these questions as we move into the new era of regulation. The answer is that the current Nurses Act (1991) and regulations are inadequate with regard to the education and practice of midwifery and this has an effect on the standard of contemporary midwifery roles and practices. The current regulatory system subsumes midwifery into nursing and this is not sufficient to protect the public, in ensuring that minimum professional standards are met. The public need to be informed to be able to discern if they are receiving care from a midwife or a nurse, a doctor or a student of any health profession. The skills and practices of each profession are distinct and different and the public has a right to this information. This is becoming increasingly important as, across the state there are employers who are actively seeking to maximise midwives' contributions through the development of models of care that increase midwives' autonomy and level of accountability. Conversely, there may also be employers who are considering models of maternity care involving nurses as the main care providers. This situation is allowed to continue within the current legislation and the public are none the wiser.

Greater visibility and recognition of



midwifery within regulation are the foundations upon which our profession is built and assessed. Minimum standards of midwifery practice and the regulation of the profession are integral to ensuring protection of the public. Without these essentials in place within regulation, midwives will continue to struggle to maintain their capacity to contribute to effective maternity service provision.

Membership of the 'Nursing and Midwifery' Boards of the future will need to clearly identify midwifery as distinct from nursing in order to ensure that 'profession specific' issues are addressed by the relevant group, with involvement of all key stakeholders. Midwifery and consumer representation should be evident on all bodies concerned with midwifery practice and education standards as well as with peer review and complaints mechanisms regarding the professional conduct of midwives. It is our partnerships with women that are unique and integral to the role of midwifery and this should be recognised and enshrined in statute. Together we all must work towards greater visibility and understanding of what midwifery is and also continue the long and hard fought struggle to achieve recognition and visibility within the laws and Acts of this state. We look forward to celebrating significant progress on both of these endeavours very shortly.

Heading into the future

This report is going to press within days of my re-election as the President of the NSWMA for the term 2003-2005. I am honoured to be asked to again lead the organisation and I am excited at the prospects that loom for us here in NSW.

Midwives across NSW and further afield are currently facing a number of exciting challenges and potential professional cross roads. Before the year ends in NSW we may be celebrating:

- ▲ the arrival of a new 'Nurses and Midwives' Act
- ▲ an announcement that the 3-year Bachelor of Midwifery Degree will commence and
- ▲ news that the state government will support the introduction of primary models of maternity care where midwives are the primary carer.

If any or all of these outcomes are achieved this will be one of the most significant years for midwifery in NSW in our pursuit of greater visibility and better maternity care for women.

How will the majority of midwives see these developments? From what many of our members have told us these changes are what is needed. In particular the support for and recognition of midwives as primary carers is most welcome. With this in mind and following a request from the Australian Society of Independent Midwives we recently held a half day forum with midwives and consumers who are involved in setting up (or planning) primary midwifery models in the area health services around NSW. The agreed purpose of the meeting was to:

- ▲ reach consensus on a range of principles that best frame a sustainable model of midwifery care that is women centred and has a known midwife as primary care giver and to
- ▲ advance an agreed strategy to influence state policy on the implementation of maternity services

The workshop was a focused session in which we discussed and built consensus around a number of key components or guiding principles for midwifery models of care. This was intended to clarify and offer some guidance as well as to ensure a degree of consistency in approach. Approximately 26 participants contributed with passion, knowledge and enthusiasm to the process, which enabled us to develop agreement on several key items. These ranged from clarification of definitions such as 'woman centred care' to debate about the meaning of the terms 'known midwife' and 'continuity of care'. We also explored the need for frameworks for ongoing education, clinical support and collaborative peer review. The allocation and organisation of work (work practices, union, state wide negotiation, annualised salaries, flexible hours of work, contractual arrangements) were other areas of lively discussion and information exchange as was caseload numbers and clinical competencies.

It was agreed that one of the first resources needed were consultation/maternity service guidelines. Sally Tracy agreed to provide the draft version of her work in this area for us to consider. These will form an important basis for ongoing negotiation and discussion within the area health services. Since the meeting, the ACMI have also agreed to circulate these guidelines for consideration and endorsement nationally. Please contact the office if you require copies of the notes taken at this meeting for your own resources. It is intended that we will convene another larger meeting or seminar late in 2003 or early in 2004 and open this to all who wish to attend.

Following this workshop there was a 'Models of Maternity Care Workshop' hosted by the NSW Health Department that was attended by area health services representatives (obstetric and mid-



wifery service leaders); members of both the Maternal & Perinatal Committee and the GMTT Committee. The full day program was designed to look at the evidence and potential for the development of a range of models of care that would provide primary, secondary and tertiary maternity services. This was a significant move forward by the Department of Health in examining the evidence for primary midwifery services in particular, given the risk of closure of many of the small units around the state. The discussion paper that was distributed before the workshop clearly defines primary services for low risk women with lead maternity carers being either doctor or midwife.

With Hannah Dahlen I represent our Association on the Maternal & Perinatal Committee at the NSW Health Department and we are pleased with the progress that is being made in gaining greater recognition for the role and contribution of midwives in the state's maternity services. Through greater recognition and visibility in health service planning we may begin to make a difference to the outcomes, rising intervention rates and the overall experiences of women. We can only do at if we are visible and strong as your professional body. We get stronger with more members. Sign up a new member today and together lets make midwifery more visible in health service planning, provision and in the wider community that we serve.

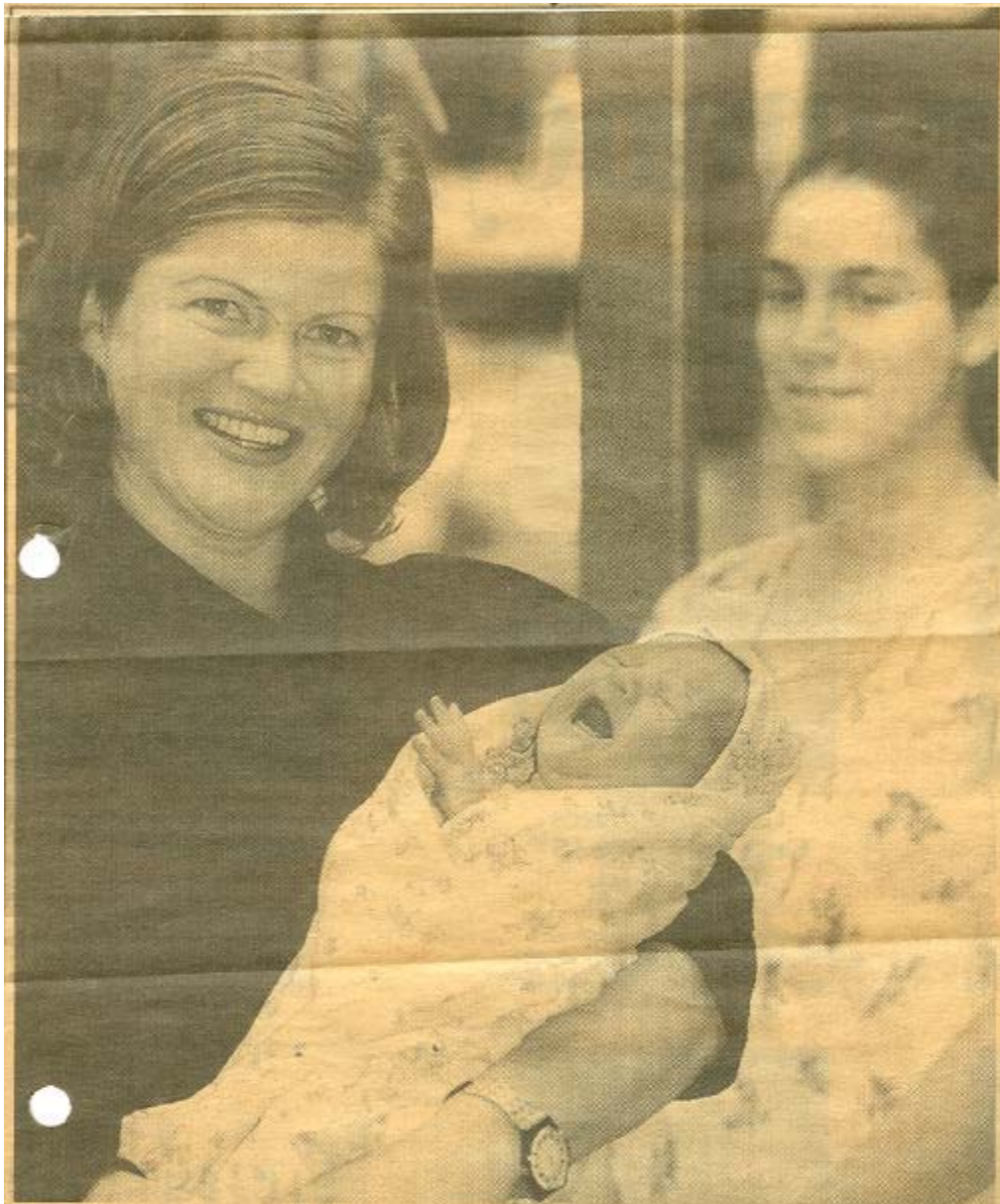
APPENDIX G: RANGE OF MEDIA ACTIVITIES THAT SOUGHT TO RAISE THE PROFILE, RECOGNITION AND STATUS OF MIDWIFERY

(Additional samples of radio interviews; newspaper articles etc from 2000 to 2003 that are relevant to the portfolio – audio and video tapes available on request)

- Radio Interview: ABC Radio National 7.02 'Life Matters' 3 April 2001
- Radio Interview: Radio 2KY Sydney News item 5 May 01
- Radio Interview: ABC Radio Regional 2BL 'Sally Loane Program' 15 November 01
- Radio Interview: ABC Radio National 7.02 'James Valentine Program' 2May 02
- Television Interview: National Program Channel 9 'The Today Program' 24 April 02

All of these interviews involved promotion of the role of the midwife and to advocate for greater access to midwifery services within the public health system. Drawing on the evidence of the benefits of midwifery care, the principle of a woman's right to choose as well as the cost effectiveness of midwifery, these opportunities were used to raise awareness and to inform the public and the media.

SEE FOLLOWING PAGES FOR SOME SAMPLES.



Midwife Liane Warden holds baby Miranda Garofalow as proud mum Elvira looks on

Birth of a trend for midwives

MORE new mums are opting for midwives rather than doctors to perform the delivery of their babies, it was claimed today.

On the eve of International Midwives Day tomorrow, authorities said the community was growing to respect the role of midwives.

NSW Midwives Association spokeswoman Pat Brodie said today an increasing number of mums-to-be were choosing midwifery over more traditional methods of childbirth.

She said that while no statistical information existed about the improved status of midwives in the community, anecdotal evidence showed that more women were choosing midwives for economic and practical reasons.

"Given that 85 per cent of births

By KATHRYN HANES

are normal not every woman needs a doctor," she said.

"Midwives make very practical and economic sense.

"Many people still think of midwives as they were seen hundreds of years ago as old women that came out in the middle hours of the night.

"We're trying to dispel the myths about midwifery and the Charles Dickens images some people still have.

"In the 90s midwives are educated, professional, accessible and respectable.

"We're not anti doctors, just want to be seen as professionals who can work in partnership with doctors and health professionals.

"Midwives offer more personalised care which allows the preg-

nant woman to develop a rapport with the midwife and improve the whole childbirth experience."

Barbara Ross, quality assurance co-ordinator at the Paddington Women's Hospital, said almost 70 per cent of the 4000 babies born at the hospital each year were delivered by midwives.

And the hospital's ante-natal clinic was one of its fastest growing units.

She said the rise of birth centres run by midwives had caused some shaking of heads in obstetric circles but their advent over a decade ago was a necessary advancement in maternity care.

International Midwives Day is a worldwide celebration of the role of midwives and part of a strategy to give parents more control over — and more choices about — the way they give birth.

Babies' lives at risk in midwife crisis

Mothers left alone at birth

By ANNA PATTY
Medical Writer

THE lives of women and babies are being placed at risk because of a national shortage of midwives to monitor them safely through labour.

The Australian College of Midwives yesterday said it was receiving an increasing number of complaints from midwives about women being left alone during childbirth.

Executive officer Alison Street said staff shortages meant midwives often were overworked, forcing them to spread their care over several patients.

Unsupervised, complications during labour could be missed, placing mother and baby in danger.

"The college has had increasing inquiries from midwives who have not been able to provide adequate care for women during birth," Ms Street said. "We have also had calls from hospitals who are trying to develop protocols for when midwives are not on duty in order to ensure the safe care of women."

"There is a critical shortage which will lead to frozen abortions in the arms of women during childbirth that could lead to deaths of babies and mothers."

A confidential inquiry into stillbirths and deaths in infancy last week linked many of the 3000 infant deaths per year in the UK to midwife staff shortages and a lack of effective training.

Pat Brodie, president of the NSW Midwives Association, said there was a shortage of 134 midwives in NSW, as part of a national shortage of up to 500.

"There should be concerns about safety in some labour wards in NSW because of the shortages," she said.

"We are very aware of the mishaps that can happen. We are talking about a midwifery crisis and that's not being too sensational."

Ms Brodie said women were requesting more drugs and interventions during pregnancy as a result of the midwife shortage.

She said there were increasing reports of midwives not being able to assist women during labour, so that in many labour wards around

Why there's a shortage

- There is a shortage of 134 midwives in NSW and up to 500 nationally.
- The average age of working midwives is 44.
- Reasons for the shortage include the cost of education which has shifted from hospitals to universities, poor working conditions and a lack of choice in work locations.
- The shortage of midwives means that midwives have less time to spend with individual patients.
- Midwives are specially trained to monitor a woman and baby through labour and to detect whether the baby is in distress.

the state, midwives are expected to care for several women at once, so they run from one woman to another," she said.

Hannah Dabbert, secretary of the NSW Midwives Association, said registered nurses were being employed in maternity units because of the midwife shortage, despite not having the specialised training of midwives.

The cost of education, working conditions and a lack of choice of working locations for midwives had contributed to the shortage. The average age of midwives in Australia is 44.

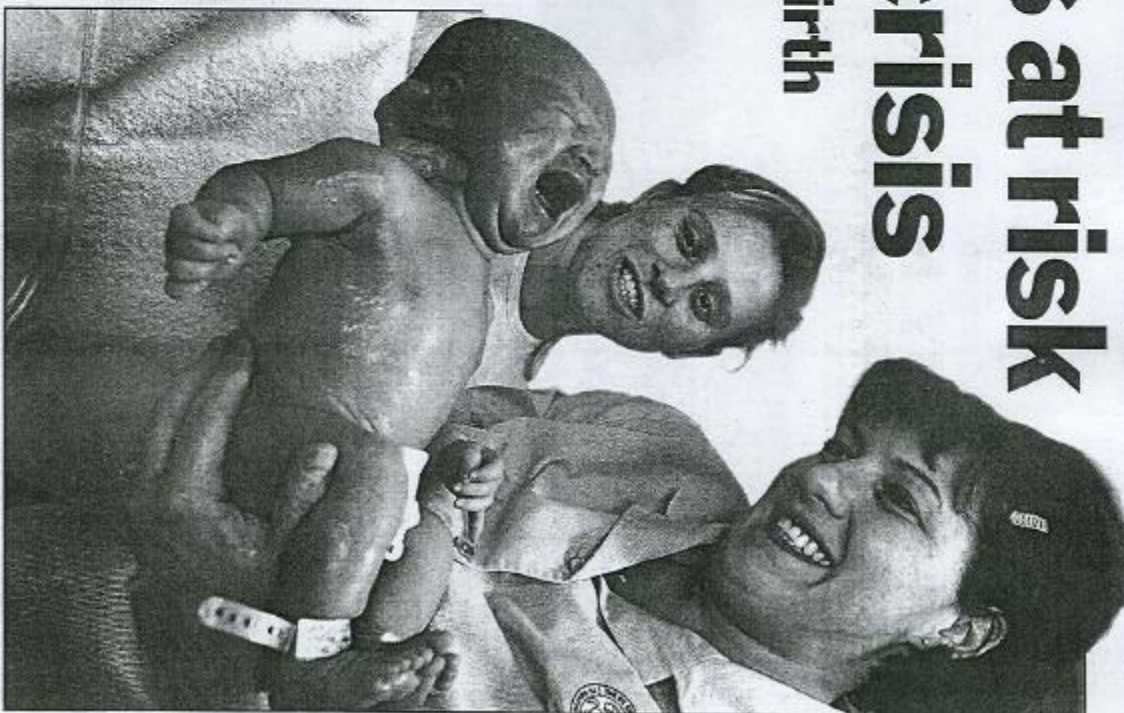
Judith McPhee, chief nursing officer for the NSW Health Department, said there was no evidence in NSW the midwife shortage had led to any adverse events or deaths.

The State Government also was actively trying to attract some of the 7000 trained midwives back into the workforce.

The NSW Nurses Act also was being reviewed with midwife shortages in mind.

Professor Lesley Barclay, director of the centre for Family Health and Midwifery at the University of Technology, said the NSW Nurses Act needed to change before a bachelor degree course for midwife training could be offered in NSW.

The three-year degree will be piloted in South Australia and Victoria next year.



Midwife Mary Donnelly with baby Shelby and mother Kristy Winchester. PHOT: STEPHEN COOPER

SMH MAY 1ST 2002

Crisis threatens midwives' practice

Chantal Rumble
Sarah Bryden-Brown

INDEPENDENT midwife Shea Caplice believes she has no option but to turn away her clients because she can't get the insurance cover she needs.

And according to Vanessa Owen, national president of the Australian College of Midwives, the indemnity insurance crisis represents the end of private midwifery in some states.

She also said the crisis could threaten midwifery in both public and private hospitals.

"Without indemnity insurance, midwifery may cease to exist in some states because hospitals could seek damages directly from the uninsured midwives," Ms Owen said.

"And for women this means a lack of choice."

After May 30, independent midwives will no longer be covered as their premiums have more than tripled and they are not a viable risk for insurance companies.



No choice: Ms Caplice examines Michelle Demasi in Sydney yesterday

The midwives believe the federal Government is ignoring them, after it excluded them from the professional indemnity summit, held at Parliament House earlier this month. "Midwives account for the greatest number of health professionals in maternity services and should

have been represented at the summit," said Pat Brodie from the NSW branch.

Ms Caplice has chosen to close her practice because she does not want to continue delivering babies at her own risk, and others are believed to be contemplating such a move.

Independent midwives uniquely offer continuous care throughout pregnancy, birth and the early stages of motherhood. They also offer home births.

Without this option, women will have to rely on public and private hospitals and birthing centres, few of which provide such care.

"If they choose me they have to pay. But now they can't (choose). They can't have their own midwife," Ms Caplice said.

Christina Cignetti gave birth to daughter Aluca at home in Sydney's Maroubra last August. Only her husband and Ms Caplice were present. She described it as a safe, rich and empowering experience.

"It's so sad that it's really limiting women's experience by giving them no choice," she said.



Pat Brodie

Pat Brodie candidly admits she has always been a rebel. As the senior research midwife for the Australian Midwifery Action Project based at UTS, a consultant midwife for St George Hospital and President of the NSW Midwives Association puts it, she realised very early in her career that she could either get out of the system or stay within it and work towards changes in the way maternity care is provided in this country. She opted to fight from the inside.

Brodie completed her nursing training at Royal Alexandra Hospital for Children in Camperdown in 1974 and worked for the next five years both here and abroad as a children's nurse. She returned to Sydney and Nepean Hospital to do midwifery, more as a career move than from any appreciation of the challenges and rewards midwifery had to offer. "From the first day I knew I had found my calling," she recalls. "It was a very challenging time to be a midwife. As a student midwife, I took part in a fundraiser to buy some comfortable chairs for the fathers. Up to that point the only seat provided for them was a small chrome thing that the anaesthetist sat on. We also bought some bean bags for the mothers which was considered very radical. In the culture we were working in maternity was regarded as a medical rather than a health condition. The first thing you did when you became pregnant was find a doctor. Midwives were pretty much invisible."

In this climate, Brodie says it was very exciting when women started demanding more rights in childbirth, requesting natural deliveries and a greater role in their pregnancy, birth and post-natal care. "It was those women who taught me how birth

could and should be," she says. "We've still got a long way to go towards putting women at the centre of care, but at a time when we're all aware of the need to listen to the consumer and respond to their needs, we have made huge advances."

Educating midwives in university was a giant step in the right direction. For the first time, instead of arguing emotionally about women's rights based on the instincts of their carers, midwives had the skills to conduct research that could be used as evidence to create change.

"Midwives have been able to change their practice because they can now access research," Brodie explains. "As a direct result, we've seen the development of team midwifery and caseload models that enable midwives to work more flexibly to better look after women before, during and after childbirth. So midwives might have a couple of clinics a week but the rest of the

access the appropriate care when it's needed."

Brodie says that while more than 60% of pregnant women at St George now access some sort of continuity of care there is still room for improvement in the models of care, the opportunities for midwives to utilise all their skills and for the development of community-based midwifery.

"I would expect that in the next few years in NSW home birthing will be an option within the public health system," she says. "There are studies being done in Fremantle and Adelaide at the moment and the evidence is quite clear that provided the service is well established and run and given skilled and competent midwives, home birth is a safe and desirable option."

Not to mention a cost effective one. Brodie adds that while the withdrawal of midwives' indemnity insurance both here and in the UK may force

I would expect that in the next few years in NSW home birthing will be an option within the public health system.

time they're on call so they can attend births as they are required rather than as their shifts dictate.

"Research shows that continuity of care is highly desirable. Apart from the psycho-social benefits, women who are familiar with their midwives are likely to be less anxious, feel more confident and have better birth outcomes. This in turn leaves them feeling more triumphant after the birth and leads to a more positive mothering experience. This is not to deny that some women will still need medical care, but it does mean that midwives can work collaboratively with doctors to help them

some independent midwives to stop practising, the long-term effect may be that it will drive further changes in the midwifery delivered by the public health system.

"It is hard to be a midwife these days," she says. "Not only are the concerns about staff shortages and quality of education, there's also the issue that a lot of midwives work autonomously and have a great level of responsibility. That's how it should be, but it also makes for an enormously challenging career."

By Kirsty McKenzie

the lamp october 2001 27

APPENDIX H: CONFERENCE PAPERS AND SEMINARS ON LEADERSHIP AND COLLABORATION

(Includes only those papers presented from 2000 to 2003 that are relevant to the portfolio)

Brodie P (2003) *Getting our Act together – making midwifery visible through collaboration* Sixth International Conference on Nursing and Midwifery Regulation Melbourne, Australia

Brodie P (2003) *Addressing the invisibility of midwifery: strategies for developing professional capital* Conference paper at the Australian College of Midwives Inc. 13th National Conference, Darwin

Brodie P (2001) *Keynote address – making midwifery happen!* Midwifery Graduation - University of Wollongong, NSW

Brodie P (2001) *Enabling midwifery: overcoming barriers to collaboration* Conference paper at the Australian College of Midwives Inc. 12th National Conference Brisbane September

Brodie P & Tracy S (2001) *Australian Midwifery Action Project: Outcomes & Actions – A way forward for midwifery* Australian College of Midwives Inc. 12th National Conference Brisbane September

Brodie P (2001). Keynote address. *Midwifery power, politics and passion: Reflections of a Nepean graduate*. Taking Midwifery to the Future. Windsor, NSW: Nepean Hospital Annual Midwifery Conference.

Brodie P (2001) *Setting the scene: Why bother changing Australian midwifery?* Managing Midwifery Seminar for midwifery managers ACE Graphics Conferences: Sydney

Brodie P (2000) *Collaboration in maternity care: a critical factor in improving outcomes ?* Midwives Marking the Millennium: the diversity of practice Bournemouth, England June 8th & 9th

Brodie P (2000) *Enriching Midwifery* National Speaking Tour – presented in twelve cities and regional centres around Australia. Invited speaker

Brodie P and S Tracy (2000) *Rural and remote midwifery: What are the issues?* Remote Midwifery Conference. Kalgoorlie, WA

Brodie P (2000) *Midwifery models of care - what works?* Invited speaker *Communities, Choices & Challenges conference* Balnagowan, Colac. Victoria

Brodie P (2000). *Team building workshop*: Community Midwifery Program. The Canberra Hospital. Canberra.

Brodie P (2000). *New models of community midwifery*. NSW Health Peak Nursing Forum (Westmead, NSW)

Brodie P (2000) *Contemporary Issues in Australian Midwifery* (Invited paper). 10th South Pacific Nurses Forum - Australian Nursing Federation, Brisbane, Queensland

**MODELS OF MATERNITY SERVICE
PROVISION ACROSS NSW
A DISCUSSION PAPER**

December 2002

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Introduction

This paper has been prepared to assist in discussion and debate about the future models of maternity service provision across NSW. Future planning decisions about the number and type of maternity units needed across metropolitan Sydney are required to progress the Maternity Services Framework. These discussions are set within the context of the Greater Metropolitan Transition Taskforce (GMTT) recommendations and discussion of the range of services and models of maternity care that are desirable. This paper is designed to provide information and evidence that can assist in those discussions. Decisions regarding models of service provision for the metropolitan area will have implications for the future planning decisions necessary for rural maternity units.

There is current evidence to support a policy shift in the redevelopment of maternity service *structures* and *systems* of care. Many of the recommended changes contained within numerous national and state government reviews into maternity services within Australia over the past decade¹ have focused on the need to provide continuity of care and increase choices for women. In particular, these reports have identified the need for greater access and a range of choices for primary care services for women with low risk pregnancies. In several other states there is evidence of reorganisation of maternity services to achieve this². These changes are being facilitated by a move towards evidence based, consumer-focussed models of public sector health care as well as the imperatives presented by the changing maternity workforce.

This context provides NSW Health with the opportunity to develop international best-practice maternity care that can meet community demands for a range of readily accessible models of care and appropriate maternity services.

Background

In 2000 NSW Health adopted the following philosophy statement for developing maternity services³:

NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services. Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate. Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.

The NSW Maternal & Perinatal Committee (M&P) has endorsed this Framework for Maternity services (2000) and implementation of its recommendations is proceeding through a working party within NSW Health Department in conjunction with the M&P Committee. A review of the *Guide to*

*Role Delineation of Health Services*⁴ has also recently been completed with significant amendments made to the 'Maternal and Child Health' section to aid clarification and classification of these core health services.

A systems approach

Using a health outcomes approach⁵ that ensures that the *structures and processes of care and prevention* have a positive impact on people's health is a well-accepted approach to reviewing 'systems' of health care. This approach involves the application of the six key dimensions of a quality health care system⁶ for the total population. These dimensions need to demonstrate:

- Safety and risk minimisation
- Effectiveness
- Appropriateness of interventions
- Consumer participation that enhances acceptability
- Access that is equitable and based on need
- Efficiency in resource utilisation

In classifying the system of maternity care under these six dimensions it is important to recognise the overlap and interlinking of issues and processes that relate to their attainment. These cross-dimensional issues⁶ include:

- Competence of the workforce
- Continuity of care
- Information management to support effective decision making
- Education and training
- Accreditation of services

Contemporary maternity services involve more than the acute services based in hospitals providing antenatal, labour, birth and postnatal care.

Consideration of future structures and system requirements needs to recognise that maternal and newborn services are provided across the interface between the community and acute facilities. This is as one part of the intersectoral Families First philosophy of networking of services. Current maternal and newborn services offer:

- Antenatal booking and regular antenatal visits
- Psychosocial screening and support services
- Pathology and ultrasound services
- Antenatal inpatient and emergency care
- Pregnancy and parenting education
- Labour and birthing care
- Newborn nursery care
- Acute postnatal and community based postnatal care
- Additional specialised services for those with extra needs
- Transport services
- Child and Family Health Services

- Networked consultation, transfer and retrieval services

A range of different health and allied health practitioners are currently involved in providing these services including:

- General Practitioners
- Midwives
- Obstetricians
- Anaesthetists
- Neonatal nurses
- Paediatricians
- Pathologists
- Ultrasonographers
- Social workers
- Physiotherapists
- Health workers from a range of specialised fields e.g. psychiatry, drug and alcohol services

Current context

Across NSW a range of different models of maternity care have been developed through local or historical patterns based on demand for services and availability of personnel. Maternal and newborn acute care services are generally networked across NSW to facilitate the transition of mothers and babies requiring higher levels of care. Improvements have occurred in the referral and networking arrangements for the care of high-risk women and babies requiring tertiary care. This now needs to be extrapolated to all levels of care with the potential to expand and strengthen these networks to optimise the use of appropriate models of care, support and education for consumers and health professionals.

Future organisational systems, networks and models of maternal and infant care across NSW will continue to incorporate contemporary evidence, 'best practice' and consumer choice and reflect recent policy initiatives including:

- Families First
- NSW Aboriginal Maternal & Infant Health Strategy
- Health Home Visiting Practice Guidelines
- Integrated Perinatal and Infant Care Program

Maternity services are traditionally mostly hospital-based and provided by a range of different health professionals. Most women see a number of different health care providers (midwives, obstetricians, general practitioners) through their pregnancy and are attended by different caregivers again in labour and during the postnatal period. Within the public health system there are issues with continuity of care across the antenatal, intrapartum or postpartum periods. There is evidence of increasing promotion of 'shared care'[#] in the

[#] /n the context of this paper 'shared care' means the provision of antenatal care by a GP, in conjunction with a public maternity hospital

antenatal period and a range of different protocols and procedures that influence the various forms of care and services available.

Availability and competence of the maternity workforce, resource allocation and authority for decision making are some of the factors that contribute to the range of models of maternity care that are currently offered.

Across Area Health Services there are systemic differences in style, philosophy and resource intensity of care provided by certified midwives, obstetricians and general practitioners to similar groups of women. There is a growing awareness of the need for a greater focus on equity of access to ensure that the services provided to women from marginalised groups, who have the poorest outcomes, are more appropriate and better utilised.

What is 'best practice' maternity care?

With the large number of births that occur (85,858 in NSW in 2001),⁷ there is a need to clearly determine what constitutes 'best practice' maternity care, in particular with regard to the care of women without complications where a normal pregnancy and birth is anticipated.

'Best practice' in maternity care can be defined for the purposes of this discussion as care that provides for the best possible outcomes for women and babies in terms of clinical safety and effectiveness.

'Best practice' maternity care recognises the effects that low socio-economic status can have on the health outcomes of women and their infants and the positive effects that a public health approach can achieve in maternity care for this group.

Future 'Best Practice Models' of maternity care for NSW will incorporate the philosophy statement as outlined in the Framework and the six key dimensions of quality as described in the NSW Quality Framework⁸. These require maternity services to demonstrate that they are safe and minimise risk whilst being effective, appropriate, involve consumer participation and ensure access, equity and efficiency.

How these processes and outcomes can be measured and reported is central to the way they are planned, developed, implemented and evaluated.

Policy directions

Findings from three comprehensive maternity service reviews⁹ have confirmed the need for maternity services to work within collaborative and consultative frameworks in order to achieve positive health outcomes and a closer matching of services to women's needs, preferences and expectations.

Within the NSW Framework for Maternity Services a range of service changes have been identified which include:

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- expanding the range of care models, including access to primary care
- increasing the availability and accessibility of services, particularly in rural and remote communities and for women from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds.
- improving the level and flexibility of available resources
- responding to consumer expectations for choice, control and continuity of care.

The recent inquiry into services at King Edward Memorial Hospital¹⁰ has made many recommendations about the future provision of maternity care that NSW Health will review and adopt as necessary. Many of these relate to clinical guidelines, credentialing and organisational management issues. In relation to models of care, this report recommends that:

"The Hospital take steps to enhance continuity of care for child-bearing women. One way this could be achieved is to make increased use of small teams of 6 – 8 midwives. Each team would take full responsibility for the care of an individual woman across each episode of care" (Rec.39)

The National Health & Medical Research Council (NHMRC)¹¹ in 1996 outlined the main issues of concern regarding maternity care for Australian women as:

- Safety
- Satisfaction, relating to
 - Continuity of care.
 - Access to and sharing of information
 - Control over the birth process

In the United Kingdom, The Expert Maternity Group commissioned to develop the Changing Childbirth Report¹², cited safety as an underlying principle of the maternity services.

"No-one cares more about the achieving a safe and happy outcome to a pregnancy than the pregnant woman and her partner. Woman want healthy babies and also to be healthy themselves after they have given birth. But this incorporates their desire to experience pregnancy, childbirth and the early days of parenthood as positive and fulfilling. Professionals working within the maternity services share this aim. The issues of safety, however, used as an over-riding principle, may become an excuse for unnecessary interventions and technological surveillance which detracts from the experience of the mother" (Page 9).

And ...

"Safety is not an absolute concept. It is part of a greater picture encompassing all aspects of health and wellbeing. We believe that safety, encompassing as it does the emotional and physical well-being of the mother and baby, must remain the foundation of good maternity care" (Page 10)

Women's satisfaction

A number of factors have been reported as contributing to 'satisfying' maternity care. These are predominately related to the way care is *organised* and the *nature* and *quality* of the care provided¹³. In relation to the *organisation* of antenatal care, women's satisfaction is related to having:

- short waiting times
- flexible appointments
- sufficient time with carers

In relation to the *nature* of care, important determinates of satisfaction include¹⁵:

- involving women in decision making about their care
- consistency of information and care
- good communication
- having caregivers who listen
- friendliness and support

Further, it has been suggested that the most valued characteristics of caregivers are¹⁴.

- the ability to provide information, advice and reassurance
- demonstrated interest in women's concerns and questions
- having enough time for discussion, rather than simply providing routine health checks

Summary

A broad social health model recognises the range of health determinants that impact on a woman's life and that can contribute to poor health outcomes for both the woman and her baby¹⁵. A strict bio-medical approach may fail to adequately reflect the broader health picture for women.

'Best practice' models of maternity care across NSW embrace an integrated social health model of maternity care that recognises the need for primary care services effectively linked and networked across primary, secondary and tertiary levels of care. Each maternity service will address women's identified needs for safe and satisfying care whilst ensuring a focus on prevention and early recognition, women's expressed wishes, timely referral, consultation and clinical effectiveness.

Future models of maternity care

The aim of maternity services in NSW is to ensure that there are service models that facilitate safe, effective collaborative maternity care that focuses on the women's specified needs. This can be achieved by ensuring the availability of primary, secondary and tertiary maternity services that enable a

seamless transition through the necessary levels of care, from home to the acute service and home again, for women and their babies.

Primary Maternity Services

Primary care may be provided in the community or in birth centres, public maternity units, and private hospitals or in a combination of these settings. For example a woman may receive all of her antenatal care in the community (clinic, doctor's rooms, home), labour and give birth in hospital, spend 24 hours in hospital (public or private) and return home to receive postnatal care from a midwife and / or her GP.

Some primary facilities, such as those in small rural towns, may not provide for planned birthing, offering inpatient postnatal care followed by community care integrated with early childhood and other community services and the woman's GP. Women accessing these services have given birth at another facility and then chosen to return closer to home for their postnatal care. These facilities have a capacity to respond to unexpected emergencies and have access to 24-hour general emergency medical care (non-obstetric) within ten minutes and the provision of basic life support and resuscitation (maternal & neonatal).

Other primary maternity facilities provide 24-hour inpatient care for normal risk women and their babies including care during labour and birth and the immediate postnatal period. This includes a capacity to respond to unexpected emergencies that may arise during the course of normal labour and birth or through unplanned presentations including provision of emergency caesarean section or operative vaginal birth. Safety and effectiveness of these units is underpinned through a collaborative framework that ensures appropriate screening and timely consultation and / or referral to obstetric and neonatal care as well as access to secondary services such as ultrasound for diagnostic or screening purposes.

A credentialing program involving midwives, general practitioners and obstetricians is systematically developed, implemented and maintained through a tiered network of service provision, education, professional support and risk management.

As a minimum standard, these facilities must have a registered midwife on-call 24 hours per day and access to 24-hour emergency medical care.

Secondary and tertiary maternity services

Secondary maternity services provide additional care during the antenatal, labour and birth and postnatal periods for women and babies who experience complications and who have a clinical need for referral or transfer.

In the public health system obstetricians provide a consultation service for pregnancy, labour and birth care, enhancing the care for women under the care of a GP or midwife. Anaesthetists provide a consultation service most

commonly for women requiring epidural pain relief or anaesthetic for operative birth or other intervention. Paediatricians provide consultations both during pregnancy, labour, at and following the baby's birth and up to six weeks afterwards. Radiologists provide ultrasound-scanning services for either diagnostic or screening purposes.

Tertiary maternity services provide a multidisciplinary specialist team for women and babies with complex and/or rare fetal-maternal needs who require access to specialised services. Tertiary services include those with:

- histories or conditions that significantly increase their risks during pregnancy, labour and birth (e.g. multiple pregnancy; hypertension)
- major fetal disorders requiring prenatal diagnostic and fetal therapy services

Private Maternity Services

Private obstetricians and accredited general practitioners provide primary, secondary and tertiary maternity services for women who choose to give birth either in a public or private hospital. Currently, approximately 28% of women access private obstetric care and 21% of all births in NSW take place in private hospitals. These services are also provided in conjunction with private paediatricians and anaesthetists. Private midwives offer women primary maternity services and the choice of birth at home or in a birth centre (public or private) although recent indemnity issues have led to a decline in the availability of this form of care.

Specialist neonatal services

Specialist neonatal services provide perinatal advice and consultation as well as inpatient care for neonates who are born with additional needs or develop additional needs prior to discharge. This includes pre term and low birth weight babies as well as any baby requiring secondary or tertiary neonatal care.

Specialist neonatal care is provided in level three, four, five and six neonatal units¹⁶. Level 3/4 units provide secondary care for babies weighing greater than 1000gms with moderate to severe complications in consultation with tertiary specialist services. These are located in both private and public hospitals. Level 5/6 or tertiary units provide all aspects of neonatal care including intensive care for the critically ill baby including those weighing less than 1000 gm or those requiring neonatal surgery.

A state wide neonatal retrieval and referral network provides specialised advice and clinical support for transfer and care of all babies requiring additional neonatal care and support by specialist neonatal services.

Future service models - core principles

Matching of services to clinical need

Primary, secondary and tertiary maternity care is accessible to all women. Primary level services must be available in primary, secondary and tertiary facilities to ensure equity of access for all women. Components of primary maternity services consist of both midwifery and medical care. The primary care provider may be a midwife, general practitioner or obstetrician who provides primary level services to the woman and facilitates access to primary, secondary and tertiary level facilities according to need. Primary care may outreach from hospitals and be provided in the community or in birth centres, public maternity units or private hospitals.

Case management or 'lead maternity carer' approach

Overall responsibility for maintaining a focus on individual needs and priorities for each woman and baby is achieved through the concept of having a 'lead maternity carer' (LMC). The LMC is responsible for ensuring that the care provided to the woman throughout her pregnancy, labour and birth and early post natal period is appropriate, safe and effective, based on her identified needs and individual situation. The 'lead maternity carer' ensures that care of the woman and her baby is seamless across the interface of acute care provision and the community based health service, as well as other agencies and the general practitioner.

Continuity of care

Continuity of care enables women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period. Continuity of care can be provided in a variety of ways. Continuity of care and consistent information is essential to the provision of care that is safe, sensitive and appropriate.

Integrated service networking

All maternity, neonatal and community health care services maintain effective linkages and networks across primary, secondary and tertiary levels of care, focusing on prevention, early recognition, timely referral, consultation and clinical effectiveness. Collaboration between health workers at all levels plus the development of a competent and flexible workforce are all critical factors in ensuring safe services

What is the evidence base for the current models of care?

NSW women enjoy a high standard of maternity care with perinatal outcomes that rank among the best in the world.

Internationally, there exists a large volume of published research into the organisation of maternity care and various models of public health sector care that involves continuity of midwifery care provided within an integrated collaborative network of services supported by obstetric caregivers. These studies report significant benefits including improved clinical outcomes and significantly increasing women's satisfaction, without increased costs.

Within the international literature there is discussion about the level of involvement of specialist obstetricians in the care of women anticipating normal childbirth. A consortium of obstetric and perinatal experts recently concluded that 'the routine involvement of doctors in the care of all women during pregnancy and childbirth is unlikely to be beneficial'¹⁷.

In the absence of evidence as to the effectiveness of this approach these researchers recommend greater multi-disciplinary team working and implementation of evidence-based guidelines to improve the rates of normal childbirth and women's satisfaction with their experiences.

Research in relation to outcomes of the various contemporary hospital based models of mainstream maternity service provision within Australia has been conducted through several randomised controlled trials of team midwifery¹⁸.

Women's views

Researchers from 'The Centre for the Study of Mother's and Children's Health' at La Trobe University, Melbourne researchers have assessed women's views of maternity care, contrasting their experiences and satisfaction using different models of care¹⁹. Researchers found that women were more likely to be satisfied with models that provided a significant level of continuity of care, in particular women were more satisfied with private medical care from an obstetrician and birth centre care provided by midwives. This study also showed that women were significantly less satisfied with 'shared care'²⁰. These findings generally reflect women's appreciation for continuity of care, fewer numbers of different carers and having opportunities to form relationships with those who will provide care before and during labour, birth and into the postnatal period.

There is also evidence that primary health based models of community midwifery care can improve outcomes for socio-economically disadvantaged and marginalised women. In southeast London since 1996, the Albany Practice²¹ has demonstrated:

- lower induction rates
- lower elective and emergency caesarean section rates
- lower rates of pethidine and epidural analgesia usage
- lower rates of episiotomy
- higher intact perineum rates
- higher vaginal birth rates
- higher rates of breastfeeding

This practice was recently cited in the UK House of Commons as an example of an effective public health strategy²²

Clinical outcomes

Internationally, researchers for the Cochrane Collaboration critically evaluated studies of continuity of midwifery care and compared their outcomes with mainstream models of maternity care for a similar population²³. This team concluded that evidence from controlled trials show that women who received continuity of midwifery care were less likely to:

- use pharmacological analgesia during labour and birth
- have labour augmented with oxytocin
- have labour length of more than 6 hours
- have a baby with a 5 minute Apgar score below 8.

Evaluation of models of continuity of midwifery care in Australia and England have shown improved outcomes associated with:

- Reduced interventions in labour, particularly augmentation of labour, analgesia and electronic fetal monitoring²⁴.
- Reduced caesarean section rates²⁵
- Enhanced experiences and satisfaction with care during pregnancy and childbirth including psychological aspects of care²⁶.
- Greater preparedness for birth and early parenting²⁷ and increased participation in decision-making²⁸.
- A positive influence on women's sense of self confidence and self esteem in the early postnatal period²⁹ which may have an important role in the prevention of postnatal distress or depression³⁰.

Fragmentation of care and conflicting advice are often cited as aspects of maternity care that are unhelpful to women³¹. Lack of rest, reducing length of stay, busy, rushed staff, inadequate time to ask questions, inappropriate or non-individualised advice with too much information provided in a short period, are other reported problems within current models care³². Community-based care, where midwives provide care in women's homes as part of a continuity of care model that is networked to GP and specialist support, has been rated highly in a number of studies¹⁸. The main reasons for the high levels of satisfaction seem to be related to continuity of carer and consistency of advice and support³³.

Costs

Costs of maternity service provision and the introduction of new models of care are important considerations in any reorganisation of health services.

There are now three Australian randomised controlled trials of models providing continuity of midwifery care for women of low to moderate risk that show their capacity to reduce costs and benefit organisations.

Reduction in overall costs can be achieved by:

- altering the ratio of midwives to doctors in the provision of antenatal care for women with uncomplicated pregnancies
- mobilising sections of the midwifery workforce to provide continuity of care.

When compared to standard care, continuity of midwifery care has been shown to reduce costs and increase effectiveness of resource utilisation³⁴.

Summary

Primary, secondary and tertiary maternity services represent a structured approach to comprehensive antenatal, postnatal and early childhood health services. Using a population based model that incorporates primary health care principles aimed at improving both the mental and physical health of mothers, their infants and families, effective services will identify mothers and or their infants who have increased medical, psychological or social risk factors.

Early identification of these factors, timely referral, assessment and provision of appropriate care and support services will contribute to reduction in the incidence of adverse physical and mental health outcomes for the woman and her infant.

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APPENDIX J: ALSO AUSTRALIA - A COLLABORATIVE APPROACH TO PROMOTING SAFE MATERNITY CARE



↔ Participants at the inaugural ALSO Providers Course held in Canberra in January 2000

ALSO australia: a collaborative approach to promoting safe maternity care

What is ALSO?

The ALSO (Advanced Life Support in Obstetrics) course is an educational program designed to assist health professionals in developing and maintaining the knowledge and practical skills needed to manage emergencies that may arise in maternity care. The course originated in the USA in 1991 and is now owned by the American Academy of Family Physicians (AAFP). ALSO has been adapted to suit the needs of thousands of practitioners across the world in countries such as the UK, Canada, Brazil, Haiti, Germany, Belgium and Nepal. In January 2001, the first group of ALSO instructors from Australia and New Zealand were trained in Canberra. We believe that, as in the UK, ALSO will become a popular and important initiative that addresses the training needs of all involved in Australian maternity services, especially those working in rural and remote areas.

The philosophy that underpins ALSO is that women and their families will benefit from the standardised, collegial and multi-disciplinary approach to maternity care that the ALSO provider course engenders. ALSO is a not-for-profit organisation that is not aligned to any one institution.

Every midwife knows that there are various safe and acceptable ways of dealing with different emergency situations. The recommended procedures covered in the course offer reasonable, consistent and evidence-based methods to enable all practitioners to identify those at risk of obstetric emergencies and to deal with unexpected crises.

Who is it for?

The ALSO Provider Course is geared to all maternity care providers including midwives, obstetricians, general practitioners, nurses, paramedics, health workers and trainees. One of the greatest strengths of ALSO is that it is only run as a multi-disciplinary course since networking and socialising are seen as crucial components to promote the collaboration, good communication and inter-professional

trust associated with improved outcomes for women and their babies. The ability to learn on an equal footing with others from a different discipline can be an eye-opening experience for all concerned and the non-hierarchical approach of ALSO breaks down barriers that have been identified as contributing to poor outcomes. An average course has 48 candidates who are divided into six groups. There are usually 14 instructors drawn from each discipline, who all teach across the syllabus.

The progress of each candidate is reviewed after the course and potential instructors are highlighted on the basis of aptitude, attitude and good communication skills. These potential instructors are invited to undertake an ALSO instructor course. This course aims to train them in teaching the ALSO material to others and helps them improve on their presentation and facilitation skills. Through teaching on ALSO courses as novice instructors, they achieve the necessary skills and confidence to become fully-fledged ALSO instructors. Instructors give their time to ALSO on a voluntary basis.

What are the objectives?

At the completion of the course, participants will be able to:

- discuss ways of improving the management of obstetrical urgencies and emergencies which may help standardise the skills of practising maternity care providers;
- discuss the importance of utilising regional maternity care services and identify possible barriers which might limit access;
- successfully complete the course written test and megadelivery station.

What is the course like?

The course is conducted over two days. There are several didactic presentations and small group hands-on workshops using lifelike models. Participants learn mnemonics to trigger appropriate responses in emergency situations. The

course finishes with a written knowledge test and a "megadelivery" hands-on skills session at the workstations to evaluate participants' procedural skills. Successful participants receive a certificate.

What does it cover?

Topics covered in the ALSO provider course are updated regularly according to the latest evidence-based practice guidelines. They can be adapted to local cultural variations and include:

- medical complications of pregnancy
- bleeding in pregnancy
- preterm labour
- electronic fetal monitoring
- dystocia
- malpresentations
- forceps and vacuum extraction
- shoulder dystocia
- birth crisis
- postpartum emergencies
- risk management
- neonatal and maternal resuscitation

How much does it cost?

The registration fees are determined by local organisers and vary depending on location and local resource.

Need more information?

For information on upcoming provider courses, or if you are interested in organising one in your area, contact the ALSO Coordinator, Rex Spinley on 0414 897 457 or by email at rspinley@ozemail.com.au

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APPENDIX K: AUSTRALIAN MIDWIFERY NEWS – A NURSES AND MIDWIVES ACT ANNOUNCED

A U S T R A L I A N
Midwifery
NEWS



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Legislative reform at last – NSW passes *Nurses and Midwives Act*

After a 12-year struggle, NSW midwives are celebrating their achievements in gaining formal recognition of midwifery within legislation, this is a first for Australian midwives.

It was as far back as October 1990 that we first submitted our paper to the NSW Health Department's Review of the Nurses Act. Like all reviews of the Health Regulation Acts at the time, this review was being conducted under the Competition Principles Policy.

We had been lobbying since the previous review in 1991 and, since that time, many passionate midwives maintained a vision and commitment to ensure that the Act would be changed. We argued that the current regulatory system subverted midwifery into nursing and that this was not sufficient to protect the public or to ensure that minimum professional standards in midwifery practice and education could be met.

Midwives' recommendations included

Our efforts were rewarded at 9.30 pm on 16 September 2003 when the Bill to amend the 1991 Nurses Act to become the *Nurses and Midwives Act* was passed through the Upper House of the NSW Parliament. The Act will be administered by a newly formed Nurses and Midwives Registration Board.

Many of the recommendations put forward by the NSW Midwives Association were included in the final submission to parliament by the Health Department. We

argued the need for a change in the view and legal positioning of the Nurses Registration Board in order for midwifery to be seen as distinct from nursing.

We sought a number of significant changes in legislation and regulation that would give proper recognition to the unique contribution that midwives make to the optimisation of maternity health outcomes. These included the development of separate registers and standing practice committees for midwifery and nursing as well as a change in name to the *Nurses and Midwives Act*. All of these recommendations were incorporated in the amendments to the Act.

Separate register for midwives

Importantly, the new Act will enable the establishment of two separate registers: one for nurses and one for midwives. It will also see the establishment of separate standing committees of the new Nurses and Midwives Registration Board, the Nurses Practice Committee and the Midwives Practice Committee. These committees will have responsibility to advise the Board on educational and other matters to do with nursing and midwifery, respectively and separately.

Greens and Democrats support midwives

The Act will result in a restructuring of the Board and an overall increase in the total number of positions up to 18. In spite of putting forward strong arguments and persistent

lobbying, we were unable to ensure that more than one of the nominated positions on the Board would be reserved exclusively for midwives. As a result, midwifery representation is undeniably inadequate.

We acknowledge the very strong support we received in lobbying for greater representation from both the Greens and the Democrats in NSW. The Greens Senator in NSW, Sylvia Hale, spoke strongly for more than one senior position for a midwife on a 16-member professional body stating: "While the Bill appears at first blush to offer midwives adequate representation on the Board, in practice they will probably be limited to a single position."

The Greens also proposed an amendment to increase the total number of Board members from 16 to 17 by adding an additional position that would be filled by a nominee of the New South Wales Midwives Association, but this was not successful.

During this historic parliamentary session, a Democrats MLC, the Honourable Dr Arthur Chesterfield-Evans, took the opportunity to remind Parliament that: "Last September the Democrats at both state and national level endorsed the Maternity Coalition's National Maternity Action Plan, which is about choice for Australian women – this initiative will greatly assist in expanding services and I am sure will lead to fewer costs associated with the public health system."

Dr Chesterfield-Evans also paid tribute to some of those who had campaigned for midwifery to be recognised within a new Act.

"I acknowledge and congratulate the following people for their good work and advocacy over the years: Pat Brodie, President of the New South Wales Midwives Association, Jan Robinson, the National Coordinator of the Australian Society of Independent Midwives, Denise Hynd and Virginia Milne from the Maternity Coalition," Dr Chesterfield-Evans said in his parliamentary address.

NSW Midwives thank both the Greens and the Democrats for their ongoing commitment and support of the ACMI, both nationally and locally. Many of you would have read the transcript from Hansard that

gives us much heart and hope for support in future campaigns for midwifery and maternity services reform in this state.

There is, however, always more work to be done to improve the overall standards of practice and regulation. We will celebrate our significant progress in this regard and then we will resume lobbying for the challenges that remain.

Competency standards needed

Determination of recency of practice is one of those challenges and an area of regulation where, nationally, there remain significant inconsistencies. Even with the new Act in place in NSW, it will be possible for a midwife to continue to register to practice, even

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